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No. (1

IN THE

Supreme Court of the United States

BRENDA L. MORGAN, individually and as Personal Representative of the Estate of Thomas Henry Morgan, Sr., Deceased,

Petitioner,

v.

NORTH MISSISSIPPI MEDICAL CENTER, INC., a Delaware Corporation,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether EMTALA imposes a federal statutory obligation on a hospital to provide stabilization treatment to an individual after admission of the individual as an inpatient from a hospital's emergency department?

2. Does a hospital have knowledge of a patient's emergency medical condition, thus placing an EMTALA obligation on the hospital to stabilize the condition, when any of the hospital's employees or attending staff first diagnose the patient's emergency medical condition or, alternatively, does a hospital have knowledge of a patient's emergency medical condition only if and when the patient's admitting physician diagnoses the condition?

LIST OF PARTIES

The names of all parties involved in this matter are listed in the caption of this Petition.

CORPORATE DISCLOSURE STATEMENT

The Petitioner makes this petition individually and as the Personal Representative of the Estate of Thomas Henry Morgan, Sr., Deceased. As such, no Corporate Disclosure Statement as required by Rule 29.6 of the Supreme Court of the United States is necessary.

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The United States Court of Appeals for the Eleventh Circuit issued its unpublished opinion on May 21, 2007. The Eleventh Circuit affirmed and adopted the opinion of the United States District Court for the Southern District of Alabama, Southern Division dated October 12, 2006. *See* Appendices A - C.

STATEMENT OF JURISDICTION

This Court's Jurisdiction is invoked under 28 U.S.C. §1254(1).

The Eleventh Circuit's opinion was rendered on May 21, 2007. Petitioner's Petition for Rehearing and Petition for Rehearing En Banc was denied on July 17, 2007. *See* Appendix E.

STATUTORY PROVISIONS AND REGULATIONS INVOLVED

42 U.S.C.A. §§ 1395dd

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR

. . .

(b) Necessary stabilizing treatment for emergency

medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition.

. . .

67 FR 31404

PROPOSED RULES AND REGULATIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

68 FR 53222

RULES AND REGULATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 C.F.R. §§ 489.24

SPECIAL RESPONSIBILITIES OF MEDICARE HOSPITALS IN EMERGENCY CASES.

The provisions of 42 U.S.C.A. §§ 1395dd, 67 FR 31404, 68 FR 53222 and 42 C.F.R. §§ 489.24 are lengthy and, therefore, set out in Appendix F, G, H and I pursuant to Supreme Court Rule 14.2(f).

STATEMENT OF THE CASE

Petitioner Brenda L. Morgan (Mrs. Morgan) asserts in this case that Respondent North Mississippi Medical Center (NMMC) violated its obligation under the Emergency Medical and Active Labor Treatment Act (EMTALA) to stabilize the known emergency medical conditions presented to NMMC by Thomas H. Morgan, deceased (Mr. Morgan), prior to his discharge to his home.

Mr. Morgan, after falling approximately twelve (12) feet from a tree, presented to the NMMC emergency room with the following emergency medical conditions: 1) pulmonary contusion, 2) multiple rib fractures, 3) right shoulder dislocation, 4) compression fractures of the lower thoracic vertebra and the upper lumbar vertebra, and 5) severe right shoulder, back and chest pain.[1] The CT

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[1] The multiple posterior rib fractures, the severe back pain and the compression fractures constituted "emergency medical conditions" as defined in EMTALA. The designation of these injuries as "emergency medical conditions" is confirmed through the testimony of three (3) physicians involved in this case: Dr. Linda Haigh, the treating and admitting physician for

scan of Mr. Morgan's abdomen and pelvis conducted in NMMC's emergency room department by radiologist Dr. Eric Emig identified the multiple right posterior lower rib fractures and the vertebral compression fractures. Mr. Morgan received no further medical evaluation of the compression fractures nor was any effort made by NMMC to stabilize this emergency medical condition prior to his discharge.

Approximately three hours after arriving at the emergency room and after his evaluation for multiple emergency medical conditions, Mr. Morgan was admitted as a patient to NMMC. Dr. Haigh's admission record did not reference Mr. Morgan's compression fractures, nor is it evident that Dr. Haigh prescribed any course of treatment for that condition at the time of admission, despite the fact that Dr. Haigh examined the same CT scan which Dr. Emig utilized when he identified compression fractures in Mr. Morgan's lower thoracic vertebral bodies. That is to say, Dr. Haigh *did not admit* Mr. Morgan for the purpose of treating the known emergency medical conditions related to his rib and vertebral fractures. Mr. Morgan was admitted to NMMC only for treatment of the pulmonary contusion and his shoulder, which had been reset in the emergency room. Mr. Morgan received, as

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Mr. Morgan while a patient of NMMC; Dr. Frederick B. Carlton, Jr., the testifying expert witness for NMMC; and Dr. E. Scott Morrison, the testifying expert witness for Mrs. Morgan.

treatment for these conditions, a pulmonary toilet[2] as well as medications for pain control for his dislocated shoulder.

Dr. Haigh became aware of Mr. Morgan's compression fractures at some point after he was admitted to NMMC. However, despite the fact that the compression fractures had been identified first by Dr. Emig in the emergency room and documented in Mr. Morgan's medical chart, and again by Dr. Haigh while treating Mr. Morgan, NMMC provided no treatment to stabilize this known emergency medical condition. In fact, no course of treatment was ever provided to stabilize this emergency medical condition.

After Mr. Morgan was admitted as an inpatient to NMMC, his medical condition began to deteriorate and he required additional medical care including oxygen and a Foley catheter. Further, the emergency medical conditions that were originally identified by Dr. Emig in the emergency room steadily worsened. However, NMMC failed to provide any stabilizing treatment for these emergency medical conditions. By 1:35 p.m., August 27, 2003, Mr. Morgan's back pain had become so debilitating that he was unable to sit up in his bed

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[2] A pulmonary toilet consists of breathing treatments to address the oxygenation and ventilation of the lungs.

and was experiencing extreme pain with movement.[3] By August 30, 2003, Mr. Morgan's condition had deteriorated to the point that Dr. Hammitt, a pain management physician, described Mr. Morgan as being in "terrible back pain" and "unable to get up".

Notwithstanding his continuous medical deterioration, which was directly related to the emergency medical conditions that had been identified initially by Dr. Emig and later by Dr. Haigh, Dr. Andrew S. Chiou, Dr. Haigh's partner, entered a discharge order on August 30, 2003 at 1:02 p.m. for Mr. Morgan to be transferred by ambulance[4] the following morning to Foley, Alabama.[5]

On August 31, 2003, the NMMC hospital staff removed Mr. Morgan's catheter and the NMMC

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[3] The NMMC physical therapist noted in Mr. Morgan's medical chart that Mr. Morgan stated "I've got to see a doctor before I do anything"; that he "can't get up due to low back pain"; and that every time he tried to move he "hurts so much he can't stand it."

[4] An ambulance, according to Dr. Chiou, was medically necessary for Mr. Morgan as he required supplemental oxygen and immobilization was required due to his "chronic LBP" (lower back pain).

[5] Mr. Morgan was discharged to his home in Foley, Alabama despite the fact that Mrs. Morgan had no previous medical training, did not know how to properly supply supplemental oxygen to her husband, did not know how to insert and withdraw a Foley catheter, and had no training in physical therapy.

ambulance service subsequently transported Mr. Morgan on a stretcher and with oxygen and pain medications to his home in Foley, Alabama. Mr. Morgan continued to suffer from significant back pain and was immobile. Upon arrival at Mr. Morgan's home in Foley, Alabama at approximately 4:30 p.m., the NMMC ambulance staff transferred Mr. Morgan from the ambulance into his bed and left him with his family. Mr. Morgan expired several hours thereafter.

Mr. Morgan's autopsy, which was performed the following day, September 1, 2003, noted "multiple blunt force injuries" with "displaced fracturing of the 10^{th} and 11^{th} thoracic vertebrae", "softening and contusions, with partial transection of underlying thoracic spinal cord", "multiple displaced right rib fractures", and "multiple abscesses surrounding fractured right ribs". These autopsy findings were in accord with the emergency medical conditions that were identified by Dr. Emig and Dr. Haigh but for which NMMC provided no stabilizing medical treatment.

Course of Proceedings

Petitioner, individually and as Personal Representative of the Estate of Thomas Henry Morgan, Sr., deceased, on August 25, 2005, filed her Complaint in the United States District Court for the Southern District of Alabama in a case styled *Brenda L. Morgan v. North Mississippi Medical Center, Inc.*, No. 05-499-WS-B alleging violations of the

Emergency Medical and Active Labor Treatment Act (EMTALA) and the common law tort of outrage. On December 2, 2005, the District Court granted in part and denied in part a Rule 12(b)(6) motion filed by NMMC relative to the EMTALA claims.[6] (*See* Appendix D). NMMC filed a Motion for Summary Judgment as to the remaining claims on August 18, 2006, which was granted by the District Court on October 12, 2006 in a memorandum opinion as to all remaining claims. (*See* Appendices B and C).

Petitioner filed her Notice of Appeal on November 13, 2006. The United States Court of Appeals for the Eleventh Circuit issued its unpublished opinion on May 21, 2007. (*See* Appendix A). Petitioner's Petition for Rehearing and Petition for Rehearing En Banc was denied on July 17, 2007. (*See* Appendix E).

REASONS FOR ALLOWANCE OF THE WRIT

I. REVIEW IS NECESSARY TO RESOLVE A CONFLICT BETWEEN THE FEDERAL COURT CIRCUITS AS TO WHETHER EMTALA IMPOSES A FEDERAL STATUTORY OBLIGATION ON A HOSPITAL TO PROVIDE

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[6] The district court granted NMMC's 12(b)(6) motion as to the §1395dd(a) screening claim(not at issue in this case), but denied the 12(b)(6) motion relative to the §1395dd(b) stabilization claim.

STABILIZATION TREATMENT TO AN INDIVIDUAL AFTER ADMISSION OF THE INDIVIDUAL AS AN INPATIENT FROM A HOSPITAL'S EMERGENCY DEPARTMENT

The Emergency Medical Treatment and Active Labor Act U.S.C.A. §1395dd ("EMTALA" or the "Act") imposes three primary duties to Medicare-provider hospital(s): (a) medical screening; (b) stabilizing treatment; (c) transfer restrictions:

(a) Medical screening requirement

In the case of a hospital *emergency department*, if any individual (whether or not eligible for benefits under this subchapter) comes to the *emergency department* and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's *emergency department*, including ancillary services routinely available to the *emergency department*, to determine whether or not an emergency medical condition (within the meaning of subsection(e)(1) of this section) exists.

42 U.S.C. §1395dd(a) (emphasis added)

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a *hospital* and the *hospital* determines that the individual has an emergency medical condition, the *hospital* must provide either-

(A) Within the staff and facilities available at the *hospital*, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) For transfer of the individual to another medical facility in accordance with subsection (c) of this section.

42 U.S.C. §1395dd(b) (emphasis added).

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a *hospital* has an emergency medical condition that has not been stabilized (within the meaning of subsection(e)(3)(B) of this section), the *hospital* may not transfer [or discharge] the individual unless-

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the *hospital's* obligations under this section and the risk of transfer, in writing

requests transfer to another medical facility,

(ii) a physician (within the meaning of Section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the *emergency department* at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in Section 1395x(r)(1) of this title), in

consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

42 U.S.C. §1395dd(c) (emphasis added).

A. The Stabilization Requirement - Conflict Among the Circuits

Circuit courts have taken a wide range of positions as to what the scope of temporal duration of the federally mandated obligation to provide stabilizing treatment is, if any, for hospitals. This Court has yet to resolve the conflict. Although not an issue directly before the Court, this Court in *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249, 119 S. Ct 685, 142 L.Ed.2d 648 (1999) addressed whether §1395dd(b) required the showing of an improper motive to establish a violation of the stabilization requirement of EMTALA. In evaluating the text of §1395dd(b), the Court held that no such requirement existed. The factual background of *Roberts* involved a patient with a medical history of being run over by a truck causing multi-faceted severe injuries. The

patient remained in the care of the hospital to which she was taken immediately after the accident for a period of six weeks, after which she was transferred to another medical facility. The Court rejected the district court's requirement that the plaintiff show an improper motive to establish a §1395dd(b) violation. Implicit in the *Roberts* decision was the continuation of EMTALA mandated stabilization for the hospital subsequent to the patient's admission and treatment as an inpatient for a period of six weeks; otherwise, the issues of alleged improper stabilization and improper transfer under §1395dd(b) and (c) would be inactionable.

In an effort to grapple with the apparent complexities of the relatively plain and unambiguous language contained in the Act, circuit courts have infused the express wording - If any individual comes to a *hospital* and the *hospital* determines that the individual has an emergency medical condition, the *hospital* must provide within the staff and facilities available at the *hospital*, for such further medical examination and such treatment as may be required to stabilize the medical condition - with a multiplicity of additional requirements and limitations so as to leave the ambit of the §1395dd(b) stabilization requirement subject to much ambiguity, uncertainty and debate.

In *Bryan v. Rectors and Visitors of University of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996), the circuit court held that the Act imposed a temporal limitation for hospitals to the "immediate aftermath"

of an emergency medication condition, limiting the hospital's §1395dd(b) stabilization requirement to the emergency room department only, ending upon the patient's admission as an inpatient. In so limiting the application of §1395dd(b), the *Bryan* court effectively substituted the specific term "emergency department" for "hospital" and interposed an ambiguous "immediate aftermath" standard.

Alternatively, other circuits have interpreted the stabilization requirement to a much broader extent, relying instead on the specific language of the Act. The circuit court in *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990) opined that the express language of §1395dd(b) required a hospital, upon determination that an emergency medical condition exists in the emergency room, to provide stabilizing treatment to the patient whether the patient remained in the emergency room or not. *Thorton* at 1134. Furthermore, this approach imposes liability for stabilization "hospital-wide", not limited to the physical boundaries of the emergency room. In *Lopez-Soto v. Hawayek*, 175 F.3d 170, 175-176 (1st Cir. 1999) the court recognized that "Congress obviously had a horizon broader than the emergency room in mind when it enacted EMTALA", based upon the inclusion of women in labor (which it concluded would often be found in the maternity ward as opposed to an emergency room) and the specific use of the term "hospital" in §1395dd(b) as opposed to the term "emergency department" utilized in §1395dd(a). *Id.* In arriving at this result, the

Lopez-Soto court relied extensively upon the "plain language reading" and "textual approach" implemented by the *Roberts* Court to evaluate the interpretation and application of the §1395dd(b) stabilization requirement to hospital care.[7] The *Lopez-Soto* court utilized time-honored canons of construction[8] to reject the "conjunctive reading approach" (reading subsections (a), (b), and (c) as interdependent and relating to a single sequence of events) of the Ninth Circuit as contained in the decision *James v. Sunrise Hosp.*, 86 F.3d 885 (9th Cir. 1996). However, the *Lopez-Soto* court stopped short of addressing whether any temporal limitation existed as to a hospital's stabilizing obligation under §1395dd(b), stating that "we leave for another day precisely how we will deal with this conundrum." *Lopez-Soto* at 177.

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[7] "Subsection (b) serves a different purpose-obligating hospitals to stabilize individuals (wherever in the hospital they may be) when emergency medical conditions are detected." *Lopez-Soto* at 175.

[8] "The fact that Congress used the "comes to an emergency department" language in subsection (a) while employing different phraseology in subsection (b) serves to emphasize the separateness of the statutory commands. 'It is generally presumed that Congress acts intentionally and purposely when it includes particular language in one section of a statue but omits it in another.'" *Lopez-Soto* at 173 quoting *BFP v. Resolution Trust Corp.*, 511 U.S. 531, 537, 114 S.Ct. 1757, 128 L.Ed.2d 556 (1994). Congress's decision to change the "emergency department" language rather than to repeat it in subsection (b) is potent evidence that Congress preferred to cast a wider net in respect to stabilization. *Lopez-Soto* at 173.

Other circuit courts further blurred the ambit of the Act in an attempt to balance the contrast between the inherently ambiguous *Bryan* "immediate aftermath" interpretive approach and the restrained "textual" approach implemented by the *Thornton* and *Lopez-Soto* courts. In *Bryant v. Adventist Health Systems/West*, 289 F.3d 1162 (9th Cir. 2002), the circuit court weighed the two approaches and sought to establish a balance between their opinions. While the *Bryant* court agreed with the *Bryan* court that a hospital's EMTALA obligations should end upon inpatient admission, it tempered such a bright-line position by adding a caveat to its analysis - an improper motive exception which requires a showing that the hospital did not admit the patient in good faith to extend EMTALA obligations beyond inpatient admission. *Bryant*, 289 F.3d at 1169. The *Bryant* court imposed yet again a motive requirement not dissimilar from the motive requirement established by the district court in *Roberts v. Galen of Virginia*, and rejected by this Court, which at the risk of repetition, succinctly stated "the provision at issue in this case [§1395dd(b)] contains no requirement of appropriateness" and held that "§1395dd(b) contains no express or implied 'improper motive' requirement." *Roberts v. Galen of Virginia, Inc.*, 525

U.S. 249, 252-253, 119 S. Ct 685, 142 L.Ed2nd 648 (1999)[9]

This revisionary approach implemented by the *Bryant* court operates to effectively modify the stabilization requirements contained in §1395dd(b) by restricting its application to the emergency department of a hospital unless the hospital admitted the patient in bad faith. The district court in the case at bar struggled with the same issues dealt with by the First, Fourth, Sixth and Ninth Circuits. Not finding any guiding precedent from the Eleventh Circuit [10] nor the Supreme Court, the district court in this case likened itself to Goldilocks, having to choose between what it described as the draconian approach of the Fourth Circuit in *Bryan*, the "too permissive" approach of the Sixth Circuit in *Thornton*, and the Ninth Circuit's approach in *Bryant*, which it determined "may be just right".[11]

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[9]While *Roberts* addressed an improper motive relative to improper stabilization, *Bryant* addressed an improper motive relative to inpatient admission.

[10]*Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002) did, as in *Roberts*, implicitly involve the question of a hospital's EMTALA obligations post-inpatient admission, although the holding addressed the requirement of a transfer under §1395dd.

[11]"The undersigned is of the opinion that the rule announced by the Ninth Circuit in *Bryant* most accurately captures the letter and spirit of EMTALA and its attendant regulations, while also remedying the inherent defects in the Fourth and Sixth Circuits' constructions of §1395dd(b)." (*See* Appendix D, pg. 64a).

(*See* Appendix D, pg. 63a). In addition to the various appellate court opinions reviewed by the district court in the instant case, the district court also sought guidance from interpretive federal regulations, which also attempt to establish parameters for hospital stabilization requirements under §1395dd(b).

B. The Stabilization Requirement - Regulatory Dilemma

(i) Inpatients *are* covered by EMTALA - the Proposed Rule

In late 1998 when this Court was considering *Roberts v. Galen of Virginia*, 525 U.S. 249 (1999), the United States Solicitor General advised this Court that the Department of Health and Human Services would develop a regulation clarifying its position on whether EMTALA applies to inpatients in a hospital. (*See* Appendix H, pg. 96a). After reviewing this issue in light of EMTALA statutory language, the Center for Medicare and Medicaid Services (CMS) drafted proposed regulatory guidelines and on May 9, 2002 issued a proposed rule (67 FR 31475) and solicited comments as to the rule. The proposed rule provided that EMTALA would apply to admitted emergency inpatients until the known emergency medical conditions were stabilized as defined in the Act. Once a hospital incurred an EMTALA obligation with respect to an individual, that obligation would continue while the individual remained at the hospital, so that any transfer to another medical

facility or discharge of the individual would be subject to the stabilization requirement. (*See* Appendix H, pg. 96a). Furthermore, the hospital's obligation to stabilize would continue to be covered by EMTALA until stabilization of all emergency medical conditions was achieved. CMS explained that its review of the statute and its legislative history[12] compelled its determination that EMTALA continued to apply to admitted emergency patients until they have been stabilized or appropriately transferred.[13](*See* Appendix H, pg. 97a). The endpoint of EMTALA obligations would be when a patient's emergency medical conditions were stabilized. (*See* Appendix H, pg. 99a).

In considering the various comments received subsequent to the publication of the proposed rule, which varied across the spectrum of the Act's applicability, CMS also considered appellate decisions on the issue in its determinations. CMS specifically referenced the *Roberts* decision of this Court and its rejection of a motive requirement in the stabilization provision of the Act, but specifically noted that the *Roberts* decision, "did not address the issue of when a hospital's decision to stabilize an

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[12]Social Security Act §§1867(b)(1)(A), (c)(2), and (e)(1); 131 Cong. Rec. 28.587 and 28.588 (1985) and H.R. Rept. No. 241(l)(1985), reprinted in 1986 U.S.C.C.A.N. 579, 605.

[13]A detailed discussion of the proposed policy on the applicability of EMTALA to admitted patients is found in the preamble to the May 9, 2002 proposed rule at 67 F.R. 31475.

individual ends." (*See* Appendix H, pg. 109a). CMS next turned to the then-recent decision of the Ninth Circuit in *Bryant v. Adventist* as well as the Fourth Circuit decision in *Bryan v. Virginia* to obtain guidance on the issue.[14] CMS distinguished the *Lopez-Soto* decision of the First Circuit by stating that the patient status of the individual, a baby, was "not clear" and therefore a rule terminating hospital EMTALA obligations at inpatient admission would not be "necessarily inconsistent." The CMS commentary is silent as the Sixth Circuit opinion in *Thornton* altogether. Interestingly, CMS cited "consistent judicial interpretation", combined with commentary received, as the basis for its final rule.[15] (*See* Appendix H, pg. 102a).

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[14]CMS also cited the Eleventh Circuit decision in *Harry v. Marchant* as supporting the view that EMTALA obligations end at inpatient admission; however, this interpretation is erroneous.

[15]CMS succinctly stated that it believed "that they (*Roberts* and *Lopez-Soto* decisions) do not pose any barrier to the position that we are taking in this rule." (*See* Appendix H, pg. 109a).

(ii) Inpatients *are not* covered by EMTALA - the Final Rule

Although initially CMS supported its position that EMTALA stabilization obligations continue beyond the emergency room and until such time as a patient is stabilized, with reference to "the statute and its legislative history," (*See* Appendix H, pg. 97a). CMS inexplicably reversed itself on this position by later stating "after reviewing the EMTALA statute and its legislative history, we find no indication that Congress intended EMTALA to apply to hospital inpatients."[16] (*See* Appendix H, pg. 106a). On September 9, 2003[17], CMS released its final rule which interprets EMTALA as providing that hospitals do not have an obligation to provide stabilizing treatment under the Act once the individual is admitted in good faith to a hospital for inpatient care, regardless of whether the individual

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[16]CMS apparently was not mindful of the appellate admonitions regarding legislative history: "Where the language of a statute is unambiguous, as it is here, we need not, and ought not, consider legislative history." *Harry v. Marchant*, 291 F.3d 767 (11th Cir. 2002), citing *United States v. Gonzales*, 520 U.S. 1, 6, 117 S.Ct 1032, 1035, 137 L.Ed 132 (1997), "Given the straightforward statutory command, there is no reason to resort to legislative history", and *Harris v. Garner*, 216 F.3d 970, 976 (11th Cir. 2000), "When the import of Congress is clear, ...we need not resort to legislative history, and we certainly should not do so to undermine the plain meaning of the statutory language."

[17]With an effective date of November 10, 2003.

is experiencing an emergency medical condition. (*See* Appendix H, pg. 96a). CMS, in following the lead of the Ninth Circuit, included a "good faith" provision in its final rule, contrary to the *Roberts* Court decision that eliminated a motive requirement under the stabilization provision of the Act.

The district court in the instant case, and the Eleventh Circuit in its opinion adoption, directly relied upon the CMS regulatory interpretation as well as the decisions of the Fourth and Ninth Circuits in applying the same good faith/bad motive requirement to Morgan in holding that "the EMTALA obligation to stabilize a patient ceases at the time of the patient's admission as an inpatient, *unless* the hospital fails to admit the patient in good faith or does so as a subterfuge to avert EMTALA liability." (*See* Appendix D, pg. 64a). Morgan contends that this legal standard is in conflict with the plain language of the Act and the decision of this Court in *Roberts* by 1) determining that NMMC's §1395dd(b) stabilization obligation was limited to the emergency department and subsequently terminated upon his admission as an inpatient, and 2) requiring the showing of a bad motive or intent on behalf of NMMC in its admission of Mr. Morgan as an inpatient to extend EMTALA liability beyond admission.

II. REVIEW IS NECESSARY TO RESOLVE A CONFLICT BETWEEN THE FEDERAL COURT CIRCUITS AS TO WHEN A HOSPITAL HAS KNOWLEDGE OF AN EMERGENCY MEDICAL CONDITION.

The Eleventh Circuit's decision creates a conflict between the circuits as to whether a hospital has knowledge of a patient's emergency medical condition, thus placing an EMTALA obligation on the hospital to stabilize the condition, when any of the hospital's employees or attending staff first diagnose the patient's emergency medical condition or, alternatively, as to whether a hospital has knowledge of a patient's emergency medical condition only if and when the patient's admitting physician diagnoses the condition.

EMTALA, pursuant to section (b) of the statute, provides "[i]f any individual comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide...such treatment as may be required to stabilize the medical condition." 42 U.S.C. §1395dd(b)(1). Thus, as a condition precedent to determining whether any duty arises under EMTALA, it is necessary to determine whether a hospital has knowledge of a patient's emergency medical condition.[18] That is to say, a hospital has a duty to

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[18]Although this court has not stated that actual knowledge of a patient's emergence medical condition is a prerequisite to liability under EMTALA, a common sense

stabilize only those emergency medical conditions of which it has knowledge. *Bryant v. Adventist Health Systems/West*, 289 F.3d. 1162 (9th Cir. 2002).

Every circuit that has addressed this issue seems to agree that a hospital's duty to stabilize a patient does not arise until the hospital detects an emergency medical condition. However, the circuits are conflicting as to their determination of *what constitutes knowledge of an emergency medical condition by a hospital.*

The Sixth Circuit has held that a hospital is responsible not only for the actions of its doctors, but for all other employees as well. *Roberts ex rel. Johnson v. Galen of Virginia*, 325 F.3d 776, 788 (6th Cir. 2003). That is to say, a hospital *has knowledge* of an emergency medical condition when *any* of its employees diagnoses such a condition. The Sixth Circuit relied upon a plain reading of the EMTALA statute to reach this decision:

> "The EMTALA statute, in all its sections, refers to the obligations of hospitals, rather than physicians. For example, the statute plainly states that a duty arises under section (b) if an individual 'comes to a hospital and *the hospital* determines

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reading of the statute requires it. *Hicklin v. WBH Evansville Inc.*, Not Reported in F.Supp.2d, 2001 WL 1768422 (S.D.Ind.).

> that the individual has an emergency medical condition.'" *Id.*

Thus, the Sixth Circuit held that certain jury instructions were erroneous as the instructions "incorrectly suggested that the hospital was only liable if the physician responsible for [the patient's] transfer knew about the [patient's emergency medical condition]." *Id.*

NMMC, in the case at bar, had knowledge, as defined by the plain language of the Act, of Mr. Morgan's emergency medical conditions. The CT scan of Mr. Morgan's abdomen and pelvis conducted in NMMC's emergency room department by radiologist Dr. Eric Emig identified the multiple right posterior lower rib fractures and the vertebral compression fractures. These conditions were further documented in Mr. Morgan's medical chart. Thus, by the rationale of the Sixth Circuit, NMMC *had knowedge* of Mr. Morgan's emergency medical conditions at the time Dr. Emig diagnosed Mr. Morgan's rib and compression fractures while he was a patient in the NMMC emergency room.

However, the Eleventh Circuit, by adopting the opinion of the district court in the instant case, has held that a hospital can only be liable under EMTALA if the physician responsible for the patient's admission knew of the patient's emergency medical condition. (See Appendix C). In other words, the view of the Eleventh Circuit is that a hospital can only be liable under EMTALA if the *admitting physician* diagnoses

the emergency medical condition.[19] Therefore, the Eleventh Circuit held that NMMC cannot be liable under EMTALA because Mr. Morgan was admitted to NMMC by Dr. Haigh in order to stabilize the emergency medical conditions that were identified by Dr. Haigh *at the time Mr. Morgan was admitted.*[20]

The standard set forth in the case at bar by the Eleventh Circuit as to what constitutes knowledge of an emergency medical condition by a hospital is in conflict with both the standard set forth by the Sixth Circuit on this issue as well as the plain language of the Act. As such, Petitioner respectfully requests that the Supreme Court grant review of ths matter.

CONCLUSION

The conflict between the First, Fourth, Sixth, Ninth and Eleventh Circuits as well as this Court over the interpretation and application of the ambit and limits of the EMTALA stabilization obligation for hospitals, causes this issue to be ripe for judicial oversight by this Court. Additionally, the absence of

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[19] The rationale of the district court is somewhat incongruous however, considering the court's ruling that the EMTALA duty to stabilize ceases upon admission as an inpatient.

[20] NMMC had knowledge of Mr. Morgan's emergency medical condition, by the Sixth Circuit standard, when these conditions were diagnosed by Dr. Emig in the emergency room, at which time a duty to stabilize said conditions was placed on NMMC.

any controlling or uniform interpretation of the EMTALA stabilization requirement has also created a dilemma for regulatory oversight of medicare-participating hospitals. For the foregoing reasons, Petitioner respectfully requests that the Supreme Court grant review of this matter.

Respectfully submitted,

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APPENDIX

APPENDIX A - OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED AND DECIDED ON MAY 21, 2007

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 06-16017

D.C. Docket No. 05-00499-CV-WS-B

BRENDA L. MORGAN,

Plaintiff-Appellant,

versus

NORTH MISSISSIPPI MEDICAL CENTER, INC.,

Defendant-Appellee.

Appeal from the United States District Court
for the Southern District of Alabama

(May 21, 2007)

Before EDMONDSON, Chief Judge, HULL, Circuit Judge, and FORRESTER,* District Judge.

PER CURIAM:

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* Honorable J. Owen Forrester, United States District Judge for the Northen District of Georgia, sitting by designation.

After review and oral argument, the Court affirms the grant of summary judgment in favor of the Defendant-Appellee on all of the Plaintiff-Appellant's claims for the reasons outlined in the district court's through and well-reasoned orders of October 12, 2006, and December 2, 2005.

AFFIRMED.

APPENDIX B - JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ALABAMA, SOUTHERN DIVISION DATED OCTOBER 12, 2006

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ALABAMA SOUTHERN DIVISION

BRENDA L. MORGAN,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**CIVIL NO. 05-0499-WS-B**
	)	
NORTH MISSISSIPPI MEDICAL CENTER, INC.,	)	
	)	
Defendant.	)	

JUDGMENT

In accordance with the Order entered on this date, granting defendant's Motion for Summary Judgment (doc. 40), it is **ordered, adjudged and decreed** that this action be, and the same hereby is, **dismissed with prejudice.**

DONE and ORDERED this 12th day of October, 2006.

s/ WILLIAM H. STEELE
UNITED STATES DISTRICT JUDGE

APPENDIX C - ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ALABAMA, SOUTHERN DIVISION DATED OCTOBER 12, 2006

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ALABAMA SOUTHERN DIVISION

BRENDA L. MORGAN,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**CIVIL NO. 05-0499-WS-B**
	)	
NORTH MISSISSIPPI MEDICAL CENTER, INC.,	)	
	)	
Defendant.	)	

ORDER

This matter is before the Court on defendant's Motion for Summary Judgment (doc. 40). The Motion has been briefed, and is ripe for disposition at this time.[1]

I. Overview of the Case.

Thomas Henry Morgan, Sr. ("Mr. Morgan")

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[1]Under the E-Government Act of 2002, this is a written opinion and therefore is available electronically. However, it has been entered only to decide the motion or matter addressed herein and is not intended for official publication or to serve as precedent.

died in the early morning hours of September 1,2003. Ten days earlier, Mr. Morgan had sustained injuries in an accidental fall at a hunting camp near Calhoun City, Mississippi. He was seen by the North Mississippi Medical Center, Inc. ("NMMC") Emergency Department in Tupelo, Mississippi on the day of his fall, and was subsequently admitted to NMMC, where he spent the next nine days. The day before his death, Mr. Morgan was discharged by NMMC and conveyed by ambulance from NMMC to his home in Foley, Alabama, where he was left in the care of his wife. Approximately 12 hours later, Mr. Morgan passed away from complications relating to his fall.

On August 26, 2005, plaintiff Brenda L. Morgan ("Morgan"), proceeding individually and as personal representative of Mr. Morgan's estate, filed suit against NMMC in this District Court. The Complaint (doc. 1) alleged two causes of action, to-wit: (1) violation of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. §§ 1395dd *et seq.* ("EMTALA") by failing to provide appropriate medical screening on August 30, 2003 (including failure to perform an MRI scan on Mr. Morgan's back), failing to provide the necessary treatment to stabilize Mr. Morgan's condition, and discharging him in a medically unstable condition; and (2) a state-law claim of outrage alleging that NMMC's conduct was intentional and/or reckless, was so extreme as to go beyond all possible bounds of decency, and caused Morgan to suffer severe emotional distress.

After service of process, NMMC filed a Motion to Dismiss (doc. 5) that raised jurisdictional and venue objections, while also maintaining that Morgan's EMTALA cause of action was not actionable on these facts, as a matter of law. On December 5, 2005, the Court entered an Order (doc. 17) granting the Motion to Dismiss in part, but also denying it in part. In particular, the December 5

Order dismissed the EMTALA claim to the extent that it was predicated on a failure-to-screen theory, but allowed that cause of action to proceed on a failure to stabilize theory to the extent that NMMC's admission of Mr. Morgan was alleged not to be in good faith or was a ruse to avoid EMTALA's requirements. As a result of the December 5 Order, then, plaintiffs only remaining causes of action are an EMTALA failure-to-stabilize claim alleging that Mr. Morgan was not admitted in good faith in order to stabilize his emergency medical conditions, and a state-law outrage claim. NMMC now seeks summary judgment.

II. Background Facts.[2]

A. Medical Treatment.

At approximately 6: 15 p.m. on August 22, 2003, Mr. Morgan arrived at NMMC as a transfer patient from Calhoun City Hospital. (NMMC Exh. A, at M03-8.)[3] Information received by NMMC in

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[2]The Court is mindful of its obligation under Rule 56 to construe the record, including all evidence and factual inferences, in the light most favorable to the nonmoving party. *See Lofton v. Secretary of Dept. of Children and Family Services*, 358 F.3d 804, 809 (11 th Cir. 2004); *Johnson v. Governor of State of Fla.*, 405 F.3d 1214, 1217 (11 th Cir. 2005). Thus, plaintiff's evidence is taken as true and all justifiable inferences are drawn in her favor.

[3]NMMC has submitted exact duplicates of many medical records within multiple exhibits. Because such redundancy hinders efforts to review the record and clutters the court file, submission of multiple copies of the same exhibits within the same summary judgment filings is generally to be avoided. The same holds true for submission of copies of pleadings previously filed in this action.

advance of his arrival was that Mr. Morgan was a 64-year old male who had sustained injuries in a 12-foot fall from a tree stand and who was in need of specialized trauma care. (*Id.* at M02-3.) Upon arrival in the NMMC Emergency Department, Mr. Morgan's chief complaints were severe pain in his back, right shoulder and chest, and shortness of breath. (*Id.* at MO8, 12.) NMMC's emergency room undertook to provide emergency care to Mr. Morgan (who was in full spinal precautions) by taking a series of CT scans and conventional X-rays, performing a shoulder reduction, treating him with conscious sedation via morphine, and administering oxygen. (*Id.* at M06, 10-11, 13.) Mr. Morgan's emergency room physician, John A. Cantrell, M.D., diagnosed him with a pulmonary contusion, multiple rib fractures, and right shoulder dislocation. (*Id.* at MOI4.) Dr. Cantrell's notes from August 22 reflect that "[a]t this time, the patient is going to be admitted to Dr. Haigh in improved condition," based on the shoulder reduction procedure that had been performed to relocate his shoulder. (*Id.*)

Roughly three hours after arrival at the emergency room, Mr. Morgan was admitted as a patient at NMMC. (*Id.* at MO15.) The admitting physician was Linda S. Haigh, M.D. (*Id.* at M013.)[4] That evening, Dr. Haigh prepared a report reflecting that Mr. Morgan was "in no apparent distress, complaining of right shoulder pain which was somewhat eased after morphine." (*Id.* at M044.) In examining his back, Dr. Haigh observed "no obvious trauma" and "a mild bruise on the right flank." (*Id.*) In examining the many CT scans and x-rays, Dr. Haigh opined that "Dorsal and lumbar spine were

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[4] Dr. Haigh was not an employee of NMMC as of August 2003. (Haigh Dep., at 131.) It is undisputed, however, that she had admitting privileges at that facility during the relevant time period.

normal," "CT of the cervical spine was normal," and "CT of the abdomen and pelvis were normal," but that "CT of the chest demonstrates a small hemothorax with some rib fractures on the right." (*Id.*)[5] Given her diagnosis of Mr. Morgan suffering from "some right pulmonary contusion, and a relocated shoulder," Dr. Haigh devised a treatment plan of "admission for pulmonary toilet and care of the pulmonary contusion," with "medications for pain control as needed." (*Id.* at M045.) Dr. Haigh's admission record did not identify compression fracture in Mr. Morgan's thoracic vertebrae, and there is no evidence that Dr. Haigh had diagnosed that condition at that time. (Morrison Dep., at 141-42.) Dr. Haigh did not delineate any specific treatment plan for the rib fractures.

For the next nine days, Mr. Morgan remained hospitalized at NMMC. During that time period, he was seen by his primary physician (Dr. Haigh), an orthopedist, a pain specialist and a neurosurgeon. (Haigh Dep., at 137.) He received physical therapy, respiratory therapy and occupational therapy, as

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[5] Dr. Haigh's assessment was not shared by Radiologist Eric Emig, who observed the same images and found a "compression fracture involving at least one of the lower thoracic vertebral bodies. Compression fracture involving one of the upper lumbar vertebral bodies cannot be excluded." (*Id.* at M0199, M0233.) Similarly, plaintiff's expert, Dr. Morrison, maintains that the abdomen/pelvis CT scan was not negative, but was in fact positive for thoracic compression fractures. (Morrison Dep., at 136-37.) And defendant's expert, Dr. Carlton, testified that he "would not consider it negative when you have got compression fractures and when you have got a pulmonary contusion. Those are not negative findings." (Carlton Dep., at 29.) It is not clear from the record when, or if, Dr. Haigh learned of the radiologist's interpretations, but at some point during the hospitalization she became cognizant of Mr. Morgan's compression fracture.

well as nursing care and diagnostic studies, and was housed in a private room. (*Id.*) He was on oxygen throughout his hospital stay, at least in part because the rib fractures might render it difficult for him adequately to ventilate and oxygenate. (Carlton Dep., at 72-73.) Nonetheless, the medical records confirm that Mr. Morgan's hospitalization did not proceed smoothly. Following his admission, he continued to experience difficulty with his right shoulder, despite the reduction procedure that Dr. Cantrell had performed. On August 25, 2003, Mr. Morgan was seen by an orthopedist, Stephen R. Southworth, M.D., concerning his shoulder. Based on new x-rays, Dr. Southworth concluded that the shoulder had re-dislocated, and performed a closed reduction procedure under general anesthesia to attempt to relocate the shoulder. (NMMC Exh. B, at M027, 54.)

In the ensuing days, tension emerged between Mr. Morgan and NMMC health care professionals. As Dr. Haigh wrote in her discharge summary, "[t]he patient maintained himself at bed rest despite our contraindications.... He refused physical therapy and refused assistance with out [*sic*] of bed. He refused to get up and go to the bathroom or use a urinal ...." (*Id.* at M027.) Dr. Haigh expressed these concerns directly to Mr. Morgan, telling him that he had refused to do what she needed him to do to get better, and that a hospital was the worst place for him in his condition because of the high incidence of disease and germs. (Morgan Dep., at 12324.) Dr. Haigh "really wanted to get this guy up" because of the medical risks he faced if he remained supine in his hospital bed for a prolonged time period. (Haigh Dep., at 78.) Additionally, physician progress notes and physical therapy notes reflect that Mr. Morgan failed to follow physician instructions about immobilizing his right arm and keeping it in a sling and swathe, contributing to ongoing shoulder pain. (NMMC Exh. B, at M090, MO159.) Physical therapy was a particular point of contention, as his physical

therapist noted on August 26, 2003 that Mr. Morgan "is poorly motivated to participate in therapy at this time and puts forth no effort whatsoever to asst with any type of bed mobility." (*Id.* at MO159.) For his part, however, Mr. Morgan complained that his lower back hurt too much for him to move, and endured severe pain even when his bed was elevated to 45 degrees. (*Id.*) Physical therapy was again attempted the following day, with similar results. (*Id.* at MO160-61.) By August 29,2003, NMMC therapists and Dr. Southworth agreed that Mr. Morgan should be discharged from physical therapy because of his noncompliance. (*Id.* at MO163.)[6]

On August 28, 2003, Dr. Haigh consulted with George M. Hammitt, M.D., concerning Mr. Morgan's lumbar back pain. (*Id.* at M048.) Dr. Haigh consulted Dr. Hammitt because Mr. Morgan was complaining of chronic back pain, for which he had been receiving epidural steroid injections from his regular doctor in Foley, Alabama since receiving an MRI five years earlier. (*Id.* at M027.)[7] Dr. Hammitt noted the

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[6]Morgan testified that Dr. Haigh had encouraged Mr. Morgan to get out of bed to mitigate the risk of various health problems that could emerge if he remained motionless in his hospital bed. (Morgan Dep., at 108.) According to Morgan, physical therapists came to Mr. Morgan but he was unable to get up and walk, so the therapy was limited to massaging his legs and feet. (*Id.* at 109.) In this regard, the evidence most favorable to the plaintiff reflects that Mr. Morgan did not comply with physical therapists' requests not because he was being disobedient or contrarian, but because he was in such excruciating pain that he was physically unable to sit at the edge of his bed, and the like, when requested to do so. (Morgan Dep., at 116-17; Morrison Dep., at 155.)

[7]Dr. Haigh's understanding was that Mr. Morgan had "chronic back pain, which he has been treated in the past and stated there is nothing that they can do." (Haigh Dep., at 74.)

compression fracture in Mr. Morgan's lower thoracic region, observed that he was complaining of "significant pain over the thoracic and lumbar region," and "[w]ould recommend MRI of the thoracic and lumbar spine," as well as an epidural steroid injection. (*Id.* at M048-49.) Dr. Hammitt successfully performed the epidural injection on August 29, 2003, with diagnoses of degenerative disk disease and compression fracture. (*Id.* at M066.)[8] However, Mr. Morgan refused the MRI, but instead requested additional pain control. (*Id.* at M027.) Mr. Morgan complained of significant back pain throughout his hospitalization. (Carlton Dep, at 45.)

Plaintiff's expert, Dr. Morrison, is sharply critical of the treatment administered by NMMC. He opined that an MRI should have been done with

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According to Dr. Haigh, Mr. Morgan advised her, "this is my same back pain that responds to epidural," rather than a new condition arising from his 12-foot fall. (*Id.* at 78.) She further testified that, while Mr. Morgan's compression fractures constituted part of an emergency medical condition, her conclusion was that they were "likely old," or part of a pre-existing ailment that predated the accident. (*Id.* at 46,48.) In Dr. Haigh's view, there was "no treatment" appropriate for these "old compression fractures" because they were "stable" and included "no neurologic deficit." (*Id.* at 48.) She elaborated that the x-ray films were "normal" because they did not reveal "little pieces missing" from the compressed vertebral bodies. (*Id.*) Had such pieces been missing, Dr. Haigh testified, worries would arise about "impingement on the spinal canal" and "neurologic deficit." (*Id.*) But in her view, the medical evidence at the time of Mr. Morgan's treatment did not support these concerns.

[8]In the operative notes for this procedure, Dr. Hammitt noted the "long history of lumbar pain" that Mr. Morgan had experienced, and indicated that CT scan and plain film x-rays should be reviewed to "make sure no fracture." (*Id.*)

respect to the compression fractures, that the rib fractures "should have warranted further looking," that an additional CT scan should have been performed to rule out laceration of spleen or liver, and that neurological examinations should have been performed on a daily basis. (Morrison Dep., at 140.) Dr. Morrison criticizes NMMC for not recommending the MRI of the thoracolumbar spine until August 28, six days after Mr. Morgan's admission. (*Id.* at 151.) According to Dr. Morrison, "to do what was needed for the patient from his initial emergency injuries from the fall would have been have the epidural or the epidural and the MRIs done as Dr. Hammitt recommended." (*Id.* at 157.) Had the MRI been done, Dr. Morrison opined, "the risk of death could have been reduced. If the spinal cord injury had been known about, the patient would have been sent to a rehab facility and not been sent home." (*Id.* at 173.)

During the nine days that Mr. Morgan was treated by NMMC, the total hospital charges he incurred were $24,945, including multiple x-ray charges in excess of$1,OOO each and a daily $380 charge for a private room. (NMMC Exh. A, at M0236-40.) Approximately two-thirds of these charges were incurred post-admission.

B. Defendant's Knowledge of Mr. Morgan's Ability to Pay.

On the morning of August 23,2003, roughly 12 hours after Mr. Morgan was admitted, his wife was summoned to the NMMC business office. At that time, she was asked how the Morgans intended to pay the charges for Mr. Morgan's hospital stay. (Morgan Dep., at 60-61.) Morgan was informed, "if you don't have the money to pay the bill, then you'll have to seek a finance company." (*Id.* at 62.) The NMMC employee with whom Morgan met indicated that she did not normally work Saturdays, but that sometimes she did have to do so. (*Id.*) It is

undisputed, however, that NMMC's patient account department is regularly open on Saturdays from 8 a.m. to 12 p.m., and that Saturday, August 23, 2003, was a day on which that employee was regularly scheduled to work. (Emens Aff., ¶¶ 4,5.) Aside from the August 23 meeting and one other occasion on which a nurse informed Morgan that a certain treatment would cost $75, no NMMC physician, nurse, administrator, employee or agent mentioned any financial matters to the Morgans during Mr. Morgan's nine-day hospitalization. (Morgan Dep., at 60.)[9]

Dr. Haigh testified that at no time during her care and treatment of Mr. Morgan was she ever aware that he did not have health insurance or of his ability or inability to pay for treatment. (Haigh Dep., at 132.) She had no knowledge and no information as to whether Mr. Morgan would or would not be able to pay for these services. (*Id.* at 138.) To be sure, NMMC's records do include a computerized admission/discharge record with a handwritten notation in the margins "son owns property - just hunting grounds no ins." (Plaintiffs Exh. 6, at M0257.) The undisputed evidence reveals, however, that this page was extracted from NMMC's business office records, and not from a medical file. There is no indication that Dr. Haigh or any other health care professional treating Morgan was aware at any time during his inpatient stay at NMMC that he was uninsured.

C. Discharge of Mr. Morgan.

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[9]Plaintiff's expert, E. Scott Morrison, D.O., testified that it is typical for a patient or family member to go to the hospital's business office to complete certain paperwork upon admission, and that a routine inquiry during that process concerns payment arrangements for charges incurred during the hospitalization. (Morrison Dep., at 61-62.)

Although the evidence on this point is contested, plaintiff's position is that NMMC began attempting to discharge Mr. Morgan almost from the moment that he was admitted. On August 23, the day after his admission, Dr. Haigh told Morgan that her husband was doing well and would probably be discharged the following morning. (Morgan Dep., at 224.)[10] On August 27, Dr. Haigh again informed Morgan that Mr. Morgan was "ready to be discharged," but he was not discharged at that time. (*Id.* at 232.) Morgan complains that in neither the August 23 nor the August 27 conversations did Dr. Haigh mention vertebral fractures. (*Id.* at 232-33.) Plaintiff suggests that NMMC intended to discharge Mr. Morgan at various times prior to August 31, 2003, but does not proffer evidence that NMMC ever took tangible steps to effectuate that intent.[11] It is undisputed that he was never discharged between August 22 and August 31, and that he continuously received medical care as an inpatient at NMMC

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[10] For her part, Dr. Haigh has no recollection of any such discussion, but she does not dispute that it occurred. (Haigh Dep., at 52.) That said, she opined that any statement to Morgan that the patient might be ready for discharge on August 24 was inconsistent with the facts, given her plan to consult with Dr. Southworth concerning Mr. Morgan's shoulder, as well as ongoing issues concerning the catheter and oxygen for the pulmonary contusion. (*Id.*)

[11] For example, plaintiff's proffered deposition excerpts devote significant attention to characterizing and debating the significance of an alleged discharge order of August 28, 2003. The record contains multiple unsigned, partial copies of discharge orders, including one order apparently created on August 27 for discharge on August 28 (Plaintiff's Exh. 6, at M031), but there is no evidence that these orders were ever implemented.

throughout that time period.

The medical records confirm that a "discharge planning screening" was initiated for Mr. Morgan at 11 :33 p.m. on August 22, 2003, mere hours after his admission. (Plaintiff's Exh. 6, at M025.) These records further state that NMMC staff spoke with Mr. Morgan regarding potential needs at discharge as early as the morning of August 23, and that there were also discussions concerning Mr. Morgan on "discharge planning rounds" on August 27. (*Id.*) However, the evidence in the summary judgment record is that it is entirely typical and routine for discharge planning to begin shortly after a patient's admission. (Haigh Dep., at 133.) Dr. Haigh indicated that discharge screening conferences may occur well before a patient's discharge, as nurses and other hospital personnel attempt to anticipate the discharge needs of the patient. (*Id.* at 134.)[12]

According to Dr. Haigh, no one in administration or risk management at NMMC had input into the decision to discharge Mr. Morgan, nor did they pressure her with respect to that decision. (Haigh Dep., at 132-33.) Nonetheless, she does acknowledge that she met with NMMC's risk management department concerning Mr. Morgan, but only because "[h]e was refusing physical therapy and nursing care." (*Id.* at 77.) In light of his perceived lack of cooperation, Dr. Haigh was

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[12] This testimony is reinforced by defendant's expert, Frederick B. Carlton, Jr., M.D., who indicated that such advance discharge planning "is pretty standard procedure" and that hospitals commence discharge planning "as soon as they could after the patient was admitted," without regard to ability to pay. (Carlton Dep., at 98.) "[U]sually within twenty-four hours in my experience discharge planning is begun." (*Id.* at 99-100.) Upon prodding about discharge planning as little as one hour after admission, Dr. Carlton stated, "It doesn't strike me as unusual in the least." (*Id.* at 100.)

concerned that Mr. Morgan was not improving as rapidly as he should and that the hospital environment might not be beneficial to him. (*Id.* at 78.) As of August 27, Dr. Haigh's "plan was to get him home in the next few days." (*Id.* at 74.) On August 28, she prepared discharge paperwork for Mr. Morgan; however, she did so as a courtesy to her partner, Dr. Orgler, because Dr. Haigh would not be working over the weekend and she wanted to save Dr. Orgler the trouble of preparing the discharge paperwork ifhe elected to discharge Mr. Morgan. (*Id.* at 96-97.) In her words, Dr. Haigh was merely "getting everything ready for him to go home in the next few days," as of August 28. (*Id.* at 97.) She would not have discharged him on the 28th because Mr. Morgan was still awaiting an epidural steroid injection and consultation by Dr. Hammitt. (*Id.* at 97-98, 100.)

Mr. Morgan was discharged from NMMC on August 31,2003. Morgan testified that Dr. Haigh explained that it was necessary to discharge Mr. Morgan because he was "too big of a risk," because he might get pneumonia or blood clots in his current condition if he remained at the hospital. (Morgan Dep., at 116.) In discharging Mr. Morgan, Dr. Haigh "was motivated mostly by his refusal to work with physical therapy although we knew that he was neurologically intact and his inability to cooperate with the nurses," prompting her to conclude that "he would do better in his own home environment." (Haigh Dep., at 137.) NMMC medical notes indicate that Mr. Morgan was "given strict instructions for follow-up with his physicians in Mobile, Alabama," after which "he was discharged to home in stable condition" on August 31, 2003. (NMMC Exh. B at M027-28.)[13] Although Dr. Haigh was not providing

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[13]At the time of discharge, Dr. Southworth at NMMC called Mr. Morgan's doctors in Alabama, advised them of Mr.

treatment to Mr. Morgan when he was discharged home, her opinion is that he was discharged in stable condition, and that Mr. Morgan had reached the point in his treatment at NMMC where continued care could reasonably be performed on an outpatient basis. (Haigh Dep., at 118-19.) Dr. Haigh also indicated that, at the time of Mr. Morgan's discharge, "his pain caused him to be reluctant to get up and he refused to get up." (*Id.* at 119.)

Mr. Morgan's discharge order dated August 30, 2003 provided that he was to be discharged to home when an ambulance service become available, and that transportation by ambulance was medically necessary because immobilization was required. (Plaintiffs Exh. 6, at M036.) The NMMC ambulance ride from Tupelo, Mississippi to Foley, Alabama on August 31, 2003 lasted approximately five and a half hours, and Mr. Morgan remained on oxygen for the duration of the trip. (*Id.* at M041.) The Morgans were home by 4:15 p.m. that day. (Morgan Dep., at 178.) The EMTs left Mr. Morgan in his bed, in the care of his family. (*Id.* at 179.) The record is devoid of any indication that the ambulance personnel treated Mr. Morgan discourteously or unprofessionally; to the contrary, plaintiff testified that, at the conclusion of the ambulance ride, Mr. Morgan insisted that she pay the ambulance drivers a generous tip of $50 to buy their dinners, calling them "the nicest two people I've ever seen." (*Id.* at 178-79.)

On the morning of September 1, 2003, just hours after the ambulance brought him home, Mr. Morgan died. An autopsy determined that the cause

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Morgan's treatment and back problems, and requested that they see him promptly upon his return home. (Morgan Dep., at 129.) Dr. Southworth relayed a message from the Alabama physicians that Morgan should call their office on the first business day after returning home, so that arrangements could be made to see Mr. Morgan expeditiously. (*Id.*)

of death was multiple blunt force injuries arising from his fall, and complications from same. (Plaintiff Exh.5.)

III. Summary Judgment Standard.

Summary judgment should be granted only if"there is no issue as to any material fact and the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). The party seeking summary judgment bears "the initial burden to show the district court, by reference to materials on file, that there are no genuine issues of material fact that should be decided at trial." *Clark v. Coats & Clark, Inc.*, 929 F.2d 604, 608 (11th Cir. 1991). Once the moving party has satisfied its responsibility, the burden shifts to the nonmovant to show the existence of a genuine issue of material fact. *Id.* "If the nonmoving party fails to make 'a sufficient showing on an essential element of her case with respect to which she has the burden of proof,' the moving party is entitled to summary judgment." *Id.* (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986)) (footnote omitted). "In reviewing whether the nonmoving party has met its burden, the court must stop short of weighing the evidence and making credibility determinations of the truth of the matter. Instead, the evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor." *Tipton v. Bergrohr GMBH-Siegen*, 965 F.2d 994, 999 (11th Cir. 1992) (internal citations and quotations omitted). "Summary judgment is justified only for those cases devoid of any need for factual determinations." *Offshore Aviation v. Transcon Lines, Inc.*, 831 F.2d 1013, 1016 (11th Cir. 1987) (citation omitted).

IV. Analysis.

Plaintiff is pursuing two causes of action: an EMTALA claim predicated on failure to stabilize, and a state-law outrage claim. Defendant maintains that it is entitled to entry of judgment in its favor as a matter of law on both claims.

A. EMTALA Claim.

1. Applicable Legal Standard.

The Eleventh Circuit has explained that EMTALA is violated "when a hospital either fails to adequately screen a patient, or discharges or transfers the patient without first stabilizing his emergency medical condition." *Kizzire v. Baptist Health System, Inc.*, 441 F.3d 1306, 1310 (11th Cir. 2006). Plaintiffs failure-to-screen theory having been rejected at the Rule 12(b) stage, her EMTALA claim rests exclusively on a failure-to-stabilize rationale.

Both applicable regulations and this Court's previous rulings in this case shed considerable light on the necessary showing for an EMTALA stabilization claim. In particular, implementing regulations provide that "[i]f a hospital has screened an individual ... and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities" under EMTALA. 42 C.F.R. § 489.24(d)(2)(i). A straightforward reading of this regulation is that admission of an individual as an inpatient is a complete defense to an EMTALA failure-to-stabilize claim, provided that the hospital does so in good faith in order to stabilize the emergency condition. Along those lines, this Court has held that "the EMTALA obligation to stabilize a patient ceases at the time of the patient's admission as an inpatient, unless the hospital fails to admit the patient in good faith or does so as a subterfuge to avert EMTALA

liability." *Morgan v. North Mississippi Medical Center, Inc.*, 403 F. Supp.2d 1115, 1130 (S.D. Ala. 2005).[14] Neither party has challenged the propriety of that legal standard for evaluating NMMC's stabilization defense to the EMTALA stabilization cause of action; therefore, the Court will utilize it here.

2. The Good-Faith Admission Defense.

NMMC has presented abundant evidence that it admitted Mr. Morgan in good faith in order to stabilize the emergency medical conditions with which it had diagnosed him. Upon arriving in the Emergency Room, Mr. Morgan was diagnosed with a pulmonary contusion, multiple rib fractures and a right shoulder dislocation. He received emergency treatment for his shoulder, and was admitted to NMMC for a pulmonary contusion and relocated shoulder, with a plan of administering oxygen and pain medications, and caring for the contusion. Mr. Morgan remained an inpatient at NMMC for more than a week, and received treatment for his shoulder, as well as pain medication, oxygen, and physical therapy, from Dr. Haigh and several NMMC specialists. Six days into Mr. Morgan's hospitalization, Dr. Haigh consulted with a pain

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[14]See also *Bryant v. Adventist Health Systems/West*, 289 F.3d 1162, 1168-69 (9th Cir. 2002) (holding that "EMTALA's stabilization requirement ends when an individual is admitted for inpatient care," unless "a patient demonstrates in a particular case that inpatient admission was a ruse to avoid EMTALA's requirements"); *Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp.2d 437,447 (E.D. Pa. 2004) ("the most persuasive synthesis of the law on admission as a defense to EMTALA liability is that admission is a defense so long as admission is not a subterfuge").

specialist concerning Mr. Morgan's lower back pain; which she regarded as recurrence of a chronic condition for which the patient had long been treated in Alabama. The pain specialist administered an epidural injection and recommended an MRI to investigate Mr. Morgan's back pain further; however, Mr. Morgan refused the MRI. Mr. Morgan was discharged after nine days, based on his physicians' assessment that the hospital environment was not a good place for him because he was not participating in physical therapy to a significant degree, was not moving in his bed, and was at risk for a host of serious medical maladies (blood clots, bed sores, pneumonia, and the like). Mr. Morgan's hospital charges from his stay at NMMC exceeded $24,000. This undisputed evidence raises a compelling inference that NMMC admitted Mr. Morgan in good faith and not as a subterfuge to shirk EMTALA responsibilities.

In opposition to summary judgment, plaintiffs principal argument is that the good-faith admission defense is unmerited here because Dr. Haigh did not admit Mr. Morgan "in order to stabilize the emergency medical condition," as required by EMTALA. Plaintiff points to medical records showing that, at the time of Mr. Morgan's admission, Dr. Haigh did not diagnose the vertebral compression fractures, misread applicable CT scans and x- ray films as "normal" even though they reflected these fractures, and admitted Mr. Morgan not to treat his emergency conditions related to rib fractures and compression fractures, but instead to treat the pulmonary contusion and the dislocated shoulder. Simply put, then, plaintiffs argument is that NMMC violated EMTALA because it did not admit Mr. Morgan in order to treat one set of emergency conditions (*e.g.*, rib and vertebral compression fractures), but instead admitted him in order to treat another set (*e.g.*, a pulmonary contusion and dislocated shoulder). This position

misapprehends the ambit and scope of EMTALA.

On this point, the Court finds the decision in *Vickers v. Nash General Hasp., Inc.*, 78 F.3d 139 (4th Cir. 1996), to be quite instructive. In *Vickers*, a hospital examined the decedent in the emergency room, diagnosed him with a lacerated scalp and contusions, and admitted him for treatment. Four days after he was discharged, the decedent died of a cerebral herniation and epidural hematoma produced by an undiagnosed skull fracture. The decedent's estate sued the hospital under EMTALA for failure to stabilize the skull fracture. In rejecting the stabilization claim, the Fourth Circuit opined as follows:

"On its face, [EMTALA] takes the actual diagnosis as a given, only obligating hospitals to stabilize conditions that they actually detect.... [A] stabilization claim exists when the patient had an emergency condition and the hospital *actually knew of that* condition.... The Act does not hold hospitals accountable for failing to stabilize conditions of which they are not aware, or even conditions of which they should have been aware. EMTALA would otherwise become coextensive with malpractice claims for negligent treatment."

Vickers, 78 F.3d at 145 (citations omitted). In response to the plaintiffs claim that the hospital had violated EMTALA by failing to stabilize the decedent's emergency condition (*e.g.*, his skull fracture), the Fourth Circuit disagreed, saying that the hospital had diagnosed him as suffering from a laceration and repaired same. The allegation that the hospital failed to stabilize the emergency medical condition "is thus in error" because it "fails once again to take the actual diagnosis as a given." *Id.* As for the plaintiffs attempt to impose EMTALA liability by hindsight, arguing that the hospital failed to stabilize what, in hindsight, turned out to be a

serious condition, *Vickers* explained that analysis by hindsight cannot impose EMTALA liability; rather, "a hospital must actually perceive the seriousness of the medical condition and nevertheless fail to act to stabilize it." *Id.* Citing the "lamentable outcome" for the decedent, the *Vickers* court stressed that "both the diagnosis and treatment may form the basis of state malpractice claims. Failure to stabilize claims under EMTALA are different, however, as Congress deliberately left the establishment of malpractice liability to state law." *Id.*

More generally, the law is clear that EMTALA does not establish a federal medical malpractice cause of action. *See Harry v. Marchant*, 291 F.3d 767, 770 (11th Cir. 2002) (EMTALA "was not intended to be a federal malpractice statute"); *Hoffman v. Tonnemacher*, 425 F. Supp.2d 1120, 1130 (E.D. Cal. 2006) ("EMTALA does not establish a federal malpractice cause of action nor does it establish a national standard of care."); *Morgan*, 403 F. Supp.2d at 1124 ("Courts have universally recognized that EMTALA was not conceived as a federal medical malpractice statute."). Claims that a physician or other health care provider failed properly to detect or discern the existence or severity of an emergency medical condition are not generally redressable under EMTALA, but are instead relegated to the state-law province of medical malpractice law. *See, e.g., Marshall v. East Carroll Parish Hosp. Service Dist.*, 134 F.3d 319,323 (5th Cir. 1998) ("a treating physician's failure to appreciate the extent of the patient's injury or illness, as well as a subsequent failure to order an additional diagnostic procedure, may constitute negligence or malpractice, but cannot support an EMTALA claim").[15]

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[15] *See also Roberts ex rel. Johnson v. Galen ojVirginia, Inc.*, 325 F.3d 776 (6th Cir. 2003) (finding that every circuit to consider the question has required actual knowledge of the

Taking the evidence in the light most favorable to Morgan, Dr. Haigh omitted rib fractures or compression fractures from her original treatment plan for Mr. Morgan. Plaintiff says this vitiates the good-faith admission defense to EMTALA liability because it establishes that NMMC did not admit Mr. Morgan in order to stabilize those specific conditions. As *Vickers* makes clear, however, for EMTALA purposes the diagnosis is taken as a given. EMTALA looks to whether the patient was admitted to stabilize the specific medical conditions that were actually diagnosed, not to whether the hospital properly identified all medical conditions at that time. EMTALA does not impose liability for failure to stabilize emergency medical conditions that either were not detected or whose severity was not appreciated by the hospital. The record raises several reasonable inferences as to why the compression fractures were excluded from Dr. Haigh's written diagnosis and treatment plan upon admission. The admission notes suggest that she misread the x-rays and CT scans and simply did not see the fractures.

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patient's emergency condition as a precondition to an EMTALA duty to stabilize); *Jackson v. East Bay Hospital*, 246 F.3d 1248, 1257 (9th Cir. 2001) (adopting "actual detection" rule under which condition precedent to stabilization requirement is that hospital had actual knowledge of emergency medical condition, and dispelling notion that hospital had EMTALA duty to stabilize undiagnosed condition where hospital treated only emergency condition it detected); *Hoffman*, 425 F. Supp.2d at 1130 (there is no violation of EMTALA where a hospital "fails to detect or misdiagnoses an emergency condition, and the remedy of a person so injured is through a state law medical malpractice claim"); *Stringfellow v. Oakwood Hosp. and Medical Center*, 409 F. Supp.2d 866, 871 (E.O. Mich. 2005) ("If the emergency nature of the condition is not detected, the hospital cannot be charged with failure to stabilize a known emergency condition.").

Her deposition testimony states that her assessment was that the compression fractures were old injuries requiring no treatment. Either way, plaintiffs dissatisfactions with Dr. Haigh lie squarely in the realm of improper diagnosis or treatment, and are outside the scope of EMTALA[16] It is undisputed that Dr. Haigh did diagnose Mr. Morgan with a pulmonary contusion and dislocated shoulder. The relevant question for EMTALA purposes is not whether all of Mr. Morgan's serious health problems were identified as bases for admission, but whether he was admitted in good faith to stabilize those medical conditions that were diagnosed. There can be no dispute that he was admitted to NMMC for the purpose of receiving treatment to stabilize those conditions, and that NMMC did in fact treat him for those diagnosed emergency conditions.[17] That there

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This point is clarified by the testimony of plaintiffs expert that "[i]f the spinal cord injury had been known about, the patient would have been sent to a rehab facility and not been sent home." (Morrison Dep., at 173.) Plainly, then, at the heart of plaintiffs theory of the case is the notion that NMMC should have known that Mr. Morgan had a spinal cord injury, that it did not know, and that the possession of such information would have prompted NMMC to take different stabilizing action. In the absence of any suggestion that NMMC violated its screening obligations to Mr. Morgan, however, this is not a valid or viable EMTALA theory.

[17]In that regard, plaintiffs expert concedes that "there is no evidence that [Mr. Morgan] was admitted for any purpose other than for him to receive treatment for his injuries." (Morrison Dep., at 64.) Later in his testimony, however, Dr. Morrison also opines that, at the time of Mr. Morgan's admission, NMMC officials "were not intending to stabilize the patient or give proper treatment for the initial emergency conditions." (Morrison Dep., at 172.) As the Court reads these

may have been other conditions that his admitting physician failed to diagnose or whose severity she did not grasp, and that he was not admitted in order to stabilize, cannot support an EMTALA claim, as a matter of law.[18]

3. Defendant's Attempts to Treat Mr. Morgan's Back Pain.

Any suggestion that NMMC admitted Mr. Morgan in

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statements, taken in the context of the deposition testimony, plaintiff is complaining not that NMMC admitted him with no intent to treat and stabilize his injuries, but is rather that NMMC was intending to stabilize only the dislocated shoulder and pulmonary contusion, rather than the fractures. Once again, this dissatisfaction with Dr. Haigh's diagnosis or treatment plan mayor may not rise to the level of negligence or medical malpractice under state law, but it is not actionable under EMTALA.

[18]The analysis might be different if Morgan had mustered evidence that Dr. Haigh knew of the compression fractures, appreciated their severity, and simply turned a blind eye to them to save NMMC the expense of treating them. In that event, an inference of failure to act in good faith might be presented, which would preclude the admission defense to EMTALA failure-to-stabilize liability. But the record here is devoid of any such evidence. To the contrary, Dr. Haigh's admission records classify the CT scans as normal, suggesting that she simply missed the compression fractures. Moreover, in her deposition, Dr. Haigh explained that when she did perceive the compression fractures, her assessment was that they were old (*i.e.*, not related to the 12-foot fall) and non-displaced, and that no treatment was necessary. Such an assessment mayor may not have been incorrect, negligent or otherwise culpable under state law, but it does not support an inference that Dr. Haigh was willfully ignorant of this medical condition to avoid having to treat and stabilize it.

bad faith and with no intent to treat his vertebral compression fractures is undermined by events that transpired during his hospitalization. At some point while Mr. Morgan was an in-patient, Dr. Haigh and NMMC began orienting his treatment towards ameliorating his back pain symptoms. To that end, he was prescribed a regimen of physical therapy and pain medication, and was referred to a pain specialist, Dr. Hammitt. Upon examining Mr. Morgan, Dr. Hammitt specifically noted the compression fracture, acknowledged his complaints of significant lower back pain, and recommended a course of stabilization treatment to include an epidural steroid injection and an MRI of the thoracic and lumbar spine. With Mr. Morgan's consent, the epidural steroid injection was performed on August 29, 2003. The MRI was never done. The uncontroverted evidence is that NMMC did not perform an MRI on Mr. Morgan because he declined the procedure.

Considered in the aggregate, these facts deal a crushing blow to plaintiffs EMTALA stabilization theory. Plaintiff suggests that Mr. Morgan's admission was a ruse and that NMMC never intended to treat his compression fractures, but the record is quite clear that NMMC did in fact attempt to treat that condition during his hospitalization, via pain medication, physical therapy, an epidural injection, and a recommendation of an MRI. Such actions are irreconcilable with a subterfuge theory of liability. Far from reflecting a bad-faith design not to treat his compression fracture, this evidence unequivocally shows that NMMC specifically endeavored to provide such treatment and stabilization. EMTALA requires nothing more. That Morgan may believe that such treatment efforts should have been initiated sooner in Mr. Morgan's hospitalization might be actionable under state law, but it absolutely does not state a viable claim under EMTALA.

Even more problematic from plaintiff's standpoint, the only stabilizing treatment that plaintiffs expert opined should have been performed with respect to the compression fractures was an MRI of the thoracic and lumbar spine. According to plaintiff's expert, the results of that MRI would have revealed more serious problems, prompting NMMC to discharge Mr. Morgan to a rehabilitation unit, rather than to his home. But this argument smacks of a critique of the treatment path selected by NMMC, not an allegation that NMMC did not admit Mr. Morgan in good faith in order to treat his conditions. This is not a basis for EMTALA liability. Even if it were, the fundamental defect in plaintiff's contentions relating to the failure to provide an MRI is that NMMC recommended an MRI of Mr. Morgan's back, but he refused this treatment. EMTALA is not violated by virtue of a hospital's failure to provide a diagnostic tool that the patient refuses, yet that is essentially what Morgan argues here.

Given the clear, uncontroverted evidence that NMMC endeavored to treat and stabilize Mr. Morgan's lower back pain, and that Mr. Morgan refused the one procedure that plaintiff's expert claims the hospital failed to provide, plaintiff cannot proceed on her EMTALA stabilization claim based on a theory that NMMC's admission of Mr. Morgan was a ruse to avoid stabilizing Mr. Morgan's vertebral fractures.[19]

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[19]With respect to the rib fractures, Dr. Haigh did mention these in the admission paperwork. But the record is devoid of any suggestion that NMMC should have taken further action to treat or stabilize them, much less an identification of what those stabilizing measures might have been. Nor is there any evidence that the rib fractures had not been stabilized at the time of Mr. Morgan's discharge. Even if the rib fractures were not stabilized, the relevant EMTALA question is whether

4. Plaintiff's Evidence of Subterfuge.

In a further attempt to make the requisite showing of subterfuge or bad faith, plaintiff contends that various ancillary facts raise that inference. She points to evidence that she claims establishes that NMMC was making plans to discharge Mr. Morgan on the very evening that he was admitted to the hospital. This evidence consists of a one- line entry stating "Discharge Planning Screening." (Plaintiffs Exh. 6, at M025.) That same document reflects that discharge communications occurred on August 23, and again on August 27. (*Id.*) Viewing this evidence in the light most favorable to plaintiff, it does not raise an inference of any nefarious conduct or improper intent. The undisputed testimony is that it is entirely commonplace and routine for hospitals to begin discharge planning immediately after a patient is admitted, without regard to the probable discharge date. It would therefore be unreasonable to infer from the fragmentary notes in the medical records

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NMMC admitted Mr. Morgan as an inpatient on August 22, 2003 in bad faith and without intending to treat his serious medical conditions. Plaintiff has come forward with no evidence or argument that NMMC's failure to engage in a particular protocol or procedure with respect to the rib fractures evinces a bad-faith subterfuge in admitting Mr. Morgan. At most, the Court is left with Dr. Morrison's conclusory statement that NMMC officials "were not intending to stabilize the patient or give proper treatment for the initial emergency conditions." (Morrison Dep., at 172.) Assuming that Dr. Morrison is competent to render expert opinions as to what NMMC did or did not intend to do upon admitting Mr. Morgan, this opinion is so conclusory and unsupported by record evidence that it would not reasonably be of assistance to a finder off act and cannot defeat defendant's motion for summary judgment. (Rule 702, Fed.R.Evid.)

that NMMC was malevolently scheming to expel Mr. Morgan within hours after his arrival to evade EMTALA stabilization duties.

Next, Morgan proffers evidence that at various times prior to August 31, 2003, the hospital initiated discharge proceedings for her husband, or otherwise expressed an intent to do so shortly. For example, plaintiffs evidence is that on the morning of August 23,2003, Dr. Haigh advised that Mr. Morgan would soon be ready for discharge. Moreover, a discharge order was actually prepared on August 27, for dismissal on August 28. Plaintiff relies on numerous alleged inconsistencies in Dr. Haigh's testimony regarding the August 27 discharge order.[20] But none of this evidence, even viewed in the light most favorable to plaintiff, establishes that Mr. Morgan's admission to NMMC was a mere ruse or subterfuge. Despite the statements attributed to Dr. Haigh on August 23, the August 27 discharge order, and the discharge planning notes commencing as early as August 22, Mr. Morgan was never discharged until August 31, 2003, fully nine days after his admission. He received substantial ongoing medical care and treatment for the duration of his hospitalization. That the hospital may have been discussing plans for Mr. Morgan's discharge within hours of his admission is an unremarkable fact indicative ofroutine hospital administration practices. That Dr. Haigh may have informed Morgan on August 23 that Mr. Morgan should be ready to go home soon does not raise an inference that NMMC did not intend to

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[20] There is no direct evidence in the record explaining why NMMC did not move forward with Mr. Morgan's discharge prior to August 31. Whatever the reasons might have been, there is no suggestion that some cataclysmic event prompted NMMC to change its mind or that the decision not to proceed with discharge was anything other than a voluntary decision made exclusively by Dr. Haigh and the NMMC medical team.

treat him, particularly where NMMC proceeded to provide nine uninterrupted days of treatment. That discharge orders may have been prepared prior to August 31 and not effectuated, for unknown reasons, does not, without more, reflect an evasive or improper intent.[21] In short, none of this evidence, as presented here and as viewed most favorably to Morgan, can sustain an inference that Mr. Morgan was not admitted in good faith in order to treat his emergency medical conditions of which the hospital was aware.

In a further effort to establish that NMMC violated EMTALA, plaintiff suggests that Dr. Haigh knew of Mr. Morgan's uninsured status and relied on discussions with NMMC's risk management department to make the discharge decision. The summary judgment record is to the contrary. Morgan met with NMMC's financial personnel on the morning of August 23 and divulged her husband's lack of insurance and apparent inability to pay; however, plaintiff makes no showing that this meeting was improper or otherwise adverse to the

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[21]Plaintiffs expert opines that the purported order by Dr. Haigh to discharge Mr. Morgan on August 28,2003 "was a violation of EMTALA because the hospital was not doing everything possible to stabilize that patient." (Morrison Dep., at 158.) It is the function of this Court, not plaintiffs expert witness, to construe, interpret and apply EMTALA to these facts; therefore, Dr. Morrison's opinion on the strictly legal question of whether the record facts amount to an EMTALA violation is entitled to no weight. *See Cook ex rei. Estate of Tessier v. Sheriff of Monroe County, Fla.*, 402 F.3d 1092, 1112 n.8 (11th Cir. 2005) (explaining that "testifying experts may not offer legal conclusions"); *United States v. Milton*, 555 F.2d 1198, 1203 (5th Cir. 1977) ("courts must remain vigilant against the admission of legal conclusions, and an expert witness may not substitute for the court in charging the jury regarding the applicable law").

treatment and care of Mr. Morgan. *See generally Kizzire*, 441 F.3d at 1310 (questioning about an individual's insurance status does not violate EMTALA if it does not delay screening or treatment); 42 C.F.R. § 489.24(d)(4)(iv) ("Hospitals may follow reasonable registration processes ... including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment."). Dr. Haigh testified that at no time before Mr. Morgan's discharge was she ever aware of his financial status or his ability to pay. Plaintiff attempts to discredit this testimony in two respects. First, she points to a medical record with a handwritten note that "son owns property - just hunting grounds no ins." But this document was culled from NMMC's business office records, not from any patient file that Dr. Haigh reviewed in treating Mr. Morgan. Second, plaintiff would impute wrongdoing to Dr. Haigh's meeting with risk management concerning Mr. Morgan; however, the undisputed testimony reflects that such meeting was confined to Mr. Morgan's alleged refusal to participate in physical therapy, and that neither risk management nor any other hospital administrative department had any input in the decision to discharge him. None of this evidence supports a theory that NMMC's admission of Mr. Morgan was a subterfuge or proceeded without good faith.

5. Conclusion

This Court has previously announced a standard under which plaintiff's EMTALA stabilization claim is negated by Mr. Morgan's admission to NMMC as an inpatient, unless plaintiff shows that Mr. Morgan was not admitted in good faith or that his admission was a mere subterfuge to evade liability. No party herein has challenged or disputed the propriety or correctness of that standard. NMMC admitted Mr. Morgan as a patient

for nine days. "In general ..., a hospital admits a patient to provide inpatient care." *Bryant v. Adventist Health Systems/West*, 289 F.3d 1162, 1169 (9th Cir. 2002). That was exactly what happened here. During Mr. Morgan's hospitalization, NMMC administered pain medication; took numerous CT scans and x-rays; performed procedures to relocate his shoulder; administered physical therapy; furnished consultations from a pain specialist, a neurosurgeon and an orthopedist; provided respiratory and occupational therapy; administered oxygen; provided an epidural steroid injection to relieve back pain; and recommended that Mr. Morgan submit to an MRI for further investigation of his back. This regimen of diagnosis, treatment, therapy, and pain management ran up a hospital bill exceeding $24,000, the vast majority of which was incurred after NMMC's business office had been apprised that Mr. Morgan was uninsured and unable to pay for his medical care.

Against this compelling backdrop of good-faith treatment, plaintiff has not presented evidence from which a reasonable finder of fact could conclude that Mr. Morgan's hospital admission was a mere charade. To be sure, Morgan faults NMMC's admitting physician for not diagnosing and treating her husband's vertebral compress in fractures at the outset of his stay. NMMC and its physicians mayor may not be at fault in that regard, but those dissatisfactions are actionable, if at all, only under state law, not EMTALA. Morgan complains that Mr. Morgan's back problems were not stabilized at the time of discharge, and criticizes NMMC for not administering an MRI to explore the problem further. But the record unequivocally shows that Mr. Morgan refused to submit to an MRI, despite NMMC's recommendation to the contrary. EMTALA does not require a hospital to diagnose a patient's medical conditions properly or to treat them competently, and it certainly does not oblige a

hospital to force a patient to submit to a procedure. In short, then, plaintiff believes that NMMC wronged Mr. Morgan by not properly diagnosing his back problems from the outset, by not doing enough to treat those conditions, by discharging him before the compression fracture had been stabilized, and by discharging him to his home instead of a rehabilitation center. But the EMTALA stabilization requirement does not provide a remedy for these purported slights, so long as NMMC admitted Mr. Morgan in good faith in order to treat the emergency medical conditions that it had diagnosed. The summary judgment record confirms that NMMC did just that. As such, whatever flaws or errors there may have been in Mr. Morgan's medical treatment at NMMC, no reasonable finder of fact could conclude that he was not admitted in good faith in order to stabilize the medical conditions diagnosed by the admitting physician.

For all of these reasons, plaintiffs EMTALA claim predicated on failure to stabilize is due to be, and the same hereby is, **dismissed.**

B. Outrage Claim.

Plaintiffs sole remaining cause of action is a state- law claim for outrage. The Complaint alleges that the same conduct ofNMMC that purportedly violated EMTALA "was intentional and/or reckless and was so extreme as to go beyond all possible bounds of decency and should be regarded as intolerable in our society." (Complaint, ¶ 22.) As a threshold matter, the parties cannot agree as to whether this claim is governed by Mississippi law or Alabama law. The result is the same either way.

If this cause of action is properly analyzed under Mississippi law, it is time-barred. *See McCorkle v. McCorkle,* 811 So.2d 258, 263 (Miss.App. 2001) (explaining that claim for outrageous conduct is more commonly known as intentional infliction

ofemotional distress under Mississippi law, and is subject to one-year limitations period); *Randolph v. Lambert*, 926 So.2d 941, 945-46 (Miss.App. 2006) (concluding that claim for intentional infliction of emotional distress is subject to one-year limitations period).[22] Because this action was filed on August 26, 2005, complaining of alleged wrongful acts occurring in late August 2003, any Mississippi-law claim for intentional infliction of emotional distress is plainly outside the one year limit. Plaintiff identifies no basis under which a Mississippi iteration of her purported outrage claim might comport with the requisite statute of limitations.

Instead, Morgan's position is that Alabama law governs the outrage cause of action, such that the statute of limitations poses no impediment. It is true that Alabama outrage claims are subject to a two-year limitations period, and that this action was filed within two years after the alleged tortious conduct.. *See Archie v. Enterprise Hosp and Nursing Home*, 508 So.2d 693, 695 (Ala. 1987) ("we hold that

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[22]The equivalency of Alabama outrage claims to Mississippi intentional infliction of emotional distress claims is confirmed by *Funderburk v. Johnson*, 935 So.2d 1084 (Miss. App. 2006), wherein the court explained that "[t]o prove a claim of intentional infliction of emotional distress, a plaintiff must show that the defendant's conduct was extreme and outrageous, going beyond all possible bounds of decency." *Id.* at 1100. That is closely analogous, or even identical, to the Alabama outrage standard. *Compare American Road Service Co. v. Inmon*, 394 So.2d 361, 365 (Ala. 1980) (Alabama outrage cause of action requires conduct "so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society"); *Ex parte Lumbermen's Underwriting Alliance*, 662 So.2d 1133, 1134 n.l (Ala. 1995) (indicating that Alabama's tort of outrage encompasses intentional infliction of severe emotional distress).

the tort of outrage or intentional infliction of emotional distress is governed by the two-year statute of limitations found in § 6-2-38(*l*)"). Nonetheless, Alabama courts have deemed outrage a "very limited cause of action that is available only in the most egregious circumstances." *Thomas v. BSE Indus. Contractors, Inc.*, 624 So.2d 1041, 1044 (Ala. 1993) (noting that the Alabama Supreme Court "has held in a large majority of the outrage cases reviewed that no jury question was presented"); *see also House v. Corporate Services, Inc.*, 882 F.Supp. 161, 165 (M.D. Ala. 1995) ("the Alabama Supreme Court is not predisposed to recognize that tort of outrage claims present jury questions"). So circumscribed, in fact, is the reach of the tort of outrage that the Alabama Supreme Court has allowed such claims only in three limited circumstances: "cases having to do with wrongful conduct in the context of family burials; cases where insurance agents employed heavy-handed, barbaric means to coerce a settlement; and cases involving egregious sexual harassment." *Carter v. Harris*, 64 F. Supp.2d 1182, 1194 (M.D. Ala. 1999) (citing Thomas). The touchstone of such a claim is that the defendant's conduct was "so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society." *Soti v. Lowe's Home Centers, Inc.*, 906 So.2d 916, 919 (Ala. 2005) (citations omitted).

Viewed in the light most favorable to Morgan, the record shows that NMMC hospitalized and treated Mr. Morgan for nine days for injuries sustained in a 12-foot fall, that Mr. Morgan was treated for his vertebral compression fractures with an epidural injection, that NMMC urged Mr. Morgan to participate in physical therapy to alleviate his back pain, that Mr. Morgan was unable to do so, that plaintiff's expert faulted NMMC for not performing an MRI as to Mr. Morgan's back problem, that NMMC recommended an MRI to investigate his back

pain further, that Mr. Morgan declined the MRI, that NMMC discharged Mr. Morgan because of concerns that he might develop bedsores or contract disease in the hospital (such that a home environment was a better place for him), that NMMC arranged for an ambulance to transport Mr. Morgan from Tupelo, Mississippi to his home in Foley, Alabama, that Mr. Morgan was pleased with the services provided by the emergency medical technicians, that the NMMC ambulance crew left Mr. Morgan in his own bed with his family members, that NMMC physicians had arranged with Mr. Morgan's Alabama doctors for him to be seen promptly after his return home, that Morgan had no special medical training, and that Mr. Morgan died approximately 12 hours after returning home. Considering all of these facts collectively, the Court is of the opinion that they do not support a reasonable inference that NMMC's conduct in this matter was so extreme and outrageous as to extend beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society.[23] Even if they did,

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[23]Alabama courts have been quite reticent to validate outrage claims in the health care context, or to expand the tort beyond its extraordinarily narrow parameters, even in the most egregious of circumstances. *See, e.g., Callens v. Jefferson County Nursing Home*, 769 So.2d 273 (Ala. 2000) (affirming summary judgment on outrage claim where nursing home restrained patient to insert a catheter and, in doing so, bent patient's leg until it popped audibly, resulting in fractures to hip and pubic bones and requiring surgery, then intentionally lied to patient's family about cause of injury); *Grantham v. Vanderzyl*, 802 So.2d 1077 (Ala. 2001) (summary judgment proper on outrage claim, where doctor threw patient's blood and "surgical refuse" in the face of operating room nurse with whom he was having a disagreement, causing nurse to live with prolonged uncertainty as to whether doctor's acts had exposed her to HIV, hepatitis or other communicable diseases); *Gallups v. Cotter*, 534 So.2d 585,

there is absolutely no evidence from which a reasonable factfinder could conclude that NMMC acted intentionally or recklessly to cause emotional distress. *See Ex parte Crawford & Co.*, 693 So.2d 458, 460 (Ala. 1997) (plaintiff claiming outrage must show that defendant's conduct was intentional or reckless, that it was extreme and outrageous, and that it caused severe emotional distress that no reasonable person could be expected to endure).

The events culminating in the death of Mr. Morgan were tragic. They do not, however, satisfy the formidable threshold established by Alabama courts for the tort of outrage, as a matter of law. Defendant is entitled to summary judgment on plaintiffs outrage cause of action.

V. Conclusion.

For all of the foregoing reasons, the Court finds that there are no genuine issues of material fact and that defendant is entitled to entry of judgment in its favor as a matter of law. As such, the Motion for Summary Judgment (doc. 40) is **granted**, and plaintiffs claims are **dismissed with prejudice**. A separate judgment will enter.

DONE and ORDERED this 12th day of October, 2006.

s/ WILLIAM H. STEELE
UNITED STATES DISTRICT JUDGE

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589 (Ala. 1988) (outrage claim held not actionable where physicians removed life-support equipment from brain-dead patient despite family's lack of consent).

APPENDIX D - ORDER OF THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ALABAMA, SOUTHERN DIVISION DATED DECEMBER 2, 2005

IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF ALABAMA SOUTHERN DIVISION

BRENDA L. MORGAN,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**CIVIL NO. 05-0499-WS-B**
	)	
NORTH MISSISSIPPI MEDICAL CENTER, INC.,	)	
	)	
Defendant.	)	

ORDER

This matter is before the Court on defendant North Mississippi Medical Center, Inc.'s Motion to Dismiss (doc. 5). The Motion has been briefed and is now ripe for disposition.

I. Background.

On August 26, 2005, plaintiff Brenda L. Morgan ("Morgan") filed the instant Complaint (doc. 1) in this District Court against defendant North Mississippi Medical Center, Inc. ("NMMC"), alleging a state-law claim for outrage, as well as a cause of action for violation of the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd

("EMTALA"). The well-pleaded allegations of the Complaint assert that on August 22, 2003, decedent Thomas Henry Morgan, Sr. ("Mr. Morgan") sustained serious injuries (including fractured ribs and vertebrae, a dislocated shoulder, and a pulmonary contusion) in a fall from a tree stand at a hunting camp near Calhoun City, Mississippi. (Complaint, ¶ 4.) Mr. Morgan, who did not have medical insurance, was rushed to NMMC's hospital in Tupelo, Mississippi (the "Hospital"), where he received emergency trauma care and was admitted as a patient. (*Id.*, ¶ 5.) Immediately following Morgan's arrival at the Hospital, Hospital personnel notified her that she would need to make financial arrangements right away for her husband's treatment. (*Id.*) After several stalled attempts commencing within a day after his admission, the Hospital discharged Mr. Morgan on August 31, 2003 (nine days after he was admitted), without conducting an MRI scan of his badly injured back, and despite his serious ongoing medical difficulties. (*Id.*, ¶¶ 6-10.) An ambulance owned and/or controlled by the Hospital transported Mr. Morgan to his home in Foley, Alabama, where ambulance attendants physically carried him inside the house to his bed on a stretcher. (*Id.*, ¶¶ 10-11.) Approximately 12 hours later, Mr. Morgan died from untreated injuries relating to his fall on August 22. (*Id.*, ¶ 12.)[24]

In its Motion to Dismiss, NMMC contends that

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[24]This recitation of background facts is not intended to be, nor should it be construed as, a formal or binding set of factual findings. This matter is before the Court on a Rule 12(b) motion, and plaintiff's accounts of these events are nothing more than bare allegations at this time. This Order accepts as true the well-pleaded allegations of the Complaint, but expressly refrains from making any specific findings of fact at this juncture.

dismissal of the Complaint is warranted on three distinct grounds. First, defendant maintains that this District Court lacks personal jurisdiction over it because NMMC does not possess the requisite minimum contacts with the State of Alabama to reasonably anticipate being haled into court here. Second, defendant argues that venue does not properly lie in this District Court. Third, defendant states that the EMTALA claim is not actionable, as a matter of law, and that in the absence of a viable EMTALA cause of
action there is no federal subject matter jurisdiction. Plaintiff contests each of these objections.

II. Analysis.

A. Personal Jurisdiction.

NMMC first contends that Morgan's claims must be dismissed pursuant to Rule 12(b)(2), Fed.R.Civ.P., because personal jurisdiction is nonexistent. In particular, defendant argues that it is a non-profit Delaware corporation with its principal place of business in Tupelo, Mississippi, and that it lacks the requisite minimum contacts with the State of Alabama to support exercise of personal jurisdiction over it here in a manner consistent with constitutional and statutory guarantees.

1. Legal Standard.

Where a district court in its discretion decides a personal jurisdiction issue without an evidentiary hearing, it is the plaintiff's burden to establish a *prima facie* case of personal jurisdiction over a nonresident defendant. *Meier ex rel. Meier v. Sun Int'l Hotels, Ltd.*, 288 F.3d 1264, 1269 (11th Cir. 2002); *S.E.C. v. Carrillo*, 115 F.3d 1540, 1542 (11th

Cir. 1997). Such a showing requires the presentation of evidence sufficient to withstand a motion for directed verdict. *Id.* In considering the adequacy of a plaintiff's proffer, district courts accept as true all facts alleged in the complaint, to the extent they are uncontroverted by a defendant's affidavits. *Id.* If the complaint and the defendant's affidavits conflict, then all reasonable inferences must be construed in the plaintiff's favor. *Id.* A dispositive motion alleging lack of personal jurisdiction must be denied if the allegations of the complaint state a *prima facie* case of jurisdiction. *Ruiz de Molina v. Merritt & Furman Ins. Agency, Inc.*, 207 F.3d 1351, 1356 (11th Cir. 2000).

"When a defendant challenges personal jurisdiction, the plaintiff has the twin burdens of establishing that personal jurisdiction over the defendant comports with (1) the forum state's long-arm provision and (2) the requirements of the due-process clause of the Fourteenth Amendment to the United States Constitution." *Lasalle Bank N.A. v. Mobile Hotel Properties, LLC*, 274 F. Supp.2d 1293, 1296 (S.D. Ala. 2003) (citations omitted); *see also Horizon Aggressive Growth, L.P. v. Rothstein-Kass, P.A.*, 421 F.3d 1162, 1166 (11th Cir. 2005) (similar). In Alabama, however, this two-pronged inquiry collapses into a single question because Alabama's long-arm provision permits its courts to exercise personal jurisdiction to the full extent permitted by the Due Process Clause of the Fourteenth Amendment. *See Molina*, 207 F.3d at 1356; *Lasalle Bank*, 274 F. Supp.2d at 1296; *Reliance Nat'l Indemnity Co. v. Pinnacle Cas. Assur. Corp.*, 160 F. Supp.2d 1327, 1332 (M.D. Ala. 2001). Accordingly, the critical question here is whether the exercise of personal jurisdiction over NMMC conforms with constitutional safeguards.

Due process authorizes the exercise of personal jurisdiction when "(1) the nonresident defendant has purposefully established minimum contacts with the forum;" and "(2) the exercise of jurisdiction will not offend traditional notions of fair play and substantial justice."

Carrillo, 115 F.3d at 1542 (quoting *Francosteel Corp., Unimetal-Normandy v. M/V Charm, Tiki, Mortensen & Lange*, 19 F.3d 624, 627 (11th Cir. 1994)); *see also Horizon*, 421 F.3d at 1166; *Molina*, 207 F.3d at 1356; *Lasalle Bank*, 274 F. Supp.2d at 1296-97.

The minimum contacts analysis varies depending on whether the type of jurisdiction asserted is general or specific. Indeed, facts supporting "[p]ersonal jurisdiction may be general, which arise from the party's contacts with the forum state that are unrelated to the claim, or specific, which arise from the party's contacts with the forum state that are related to the claim." *Nippon Credit Bank, Ltd. v. Matthews*, 291 F.3d 738, 747 (11th Cir. 2002). Under general jurisdiction, there must be a showing of "continuous and systematic" contacts between the defendant and the forum state even if those contacts are unrelated to the plaintiff's claims. *Id.* By contrast, specific jurisdiction is proper where (i) the defendant's contacts with the forum state are related or give rise to the plaintiff's cause of action, (ii) the contacts involve some act by which the defendant purposefully avails itself of the privilege of conducting activities within the forum, and (iii) the defendant's contacts with the forum are such that the defendant should reasonably anticipate being haled into court there. *See, e.g., McGow v. McCurry*, 412 F.3d 1207, 1214 (11th Cir. 2005); *Carrillo*, 115 F.3d at 1542; *Vermeulen v. Renault, U.S.A., Inc.*, 985 F.2d 1534, 1546 (11th Cir. 1993); *Lasalle Bank*, 274 F. Supp.2d at 1297.

2. Application of Jurisdictional Analysis to NMMC.

Plaintiff argues that, notwithstanding NMMC's lack of a business presence in Alabama, this Court may properly exercise specific jurisdiction over it.[25] To that end, the

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[25]The parties also spar as to whether NMMC-Hamilton, a 57-bed acute care hospital with nursing home, home health and wellness center services located in Hamilton, Alabama, is

Complaint may be fairly read as alleging that when NMMC discharged Mr. Morgan, it placed him in an NMMC ambulance operated by NMMC personnel. (Complaint, ¶ 10.) That NMMC ambulance is alleged to have driven Mr. Morgan from the Hospital in Tupelo, Mississippi to his home in Foley, Alabama, at which time NMMC ambulance attendants removed Mr. Morgan from the ambulance, carried him into his home by stretcher, and deposited him in his bed where he died just hours later. (*Id.*, ¶ 11.) Plaintiff's opposition brief contends that these allegations adequately establish the elements of specific jurisdiction over NMMC.

Curiously, defendant's reply brief utterly ignores the ambulance allegations and makes no attempt to rebut plaintiff's invocation of specific jurisdiction principles.[26]

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sufficient to establish general jurisdiction over this defendant. NMMC asserts that the Hamilton facility is a separate and distinct corporation from NMMC, although both share the same parent corporation. The Court's resolution of the specific jurisdiction question renders it unnecessary to explore the legal relationship between these two entities, much less the ramifications of NMMC-Hamilton's existence on the jurisdictional status of NMMC in this litigation, in order to resolve this aspect of the Motion to Dismiss.

[26]In lieu of doing so, NMMC's reply brief simply offers an affidavit stating that NMMC does business solely in Tupelo, Mississippi, and that it is not qualified, authorized or licensed to do business in Alabama. (Reply Brief, at Exh. A.) At most, such allegations create a factual dispute with Morgan's assertion in the Complaint that a NMMC ambulance operated by NMMC staff transported the decedent to his home in Alabama and left him there in an unstabilized condition. As indicated *supra*, however, all reasonable inferences must be construed in the plaintiff's favor and the Motion to Dismiss must be denied if the Complaint establishes a *prima facie* case of jurisdiction. Accordingly, NMMC's blanket denial that it engages in activities outside of Mississippi cannot overcome plaintiff's

Defendant adopts this strategy at its peril, inasmuch as this Court will not formulate a party's arguments for it. *See Resolution Trust Corp. v. Dunmar Corp.*, 43 F.3d 587, 599 (11th Cir. 1995) ("There is no burden upon the district court to distill every potential argument that could be made based upon the materials before it."); *Pinto v. Universidad De Puerto Rico*, 895 F.2d 18, 19 (1st Cir. 1990) ("The court is under no duty to exercise imagination and conjure what a plaintiff might have alleged, but did not, and do counsel's work for him or her.").[27]

Applying the three specific jurisdiction criteria to the facts asserted in the Complaint, it is clear that plaintiff has sufficiently pleaded a basis for the exercise of personal jurisdiction over NMMC in Alabama. First, NMMC's alleged contacts with the forum state (namely, its acts of transporting Mr. Morgan to his home in Foley, Alabama, physically carrying him inside the house on a stretcher, and leaving him there) are unquestionably related to plaintiff's causes of action herein. Ultimately, this case is factually centered on the propriety of the Hospital's discharge decision and the ramifications of that decision for Mr. Morgan. The Hospital's actions in transferring the decedent from the Hospital to Alabama are inextricably intertwined with, substantially related to, and ultimately form the factual predicate for plaintiff's theories of recovery. Second, when NMMC personnel traveled into Alabama in an NMMC vehicle on NMMC official business, they were certainly

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specific allegations of NMMC conduct in Alabama for purposes of the Rule 12(b)(2) Motion.

[27]Moreover, defendant does not proffer evidence that it did not own or control the ambulance, that it did not employ or control the ambulance attendants, or that the ambulance and its crew were not performing official Hospital business by transporting Mr. Morgan to Alabama. As such, this analysis assumes that Mr. Morgan traveled in an NMMC ambulance driven by NMMC personnel on NMMC business.

purposefully availing themselves of the privilege of conducting activities in Alabama. Had defendant's ambulance been struck by another motorist in Foley, Alabama, defendant would have had access to the protections of Alabama law in connection with that incident. It would defy common sense to suggest that NMMC did not intend to avail itself of the protections and benefits of Alabama law when it dispatched its agents and equipment into this State to transfer Mr. Morgan to his home. Third, NMMC should absolutely have reasonably anticipated being haled into court in Alabama in the event of any problems in connection with its ambulance foray in this State. For instance, had defendant's ambulance wrongfully struck another motorist while traversing the streets of Foley, Alabama, it would be foolhardy for defendant not to expect to be sued in Alabama for that transgression.

Simply put, the allegations of the Complaint reasonably support the inference that defendant intentionally directed Hospital personnel to travel into Alabama in a Hospital vehicle with a Hospital patient who had just been discharged. The only sensible construction of these facts is that defendant purposefully aimed its official activities into the State of Alabama. In so doing, it must have known that any difficulty that its agents encountered in Alabama might be remediable in courts in the State of Alabama pursuant to Alabama law. Plaintiff's claims against NMMC arise directly from its acts of ejecting Mr. Morgan from the Hospital, carrying him to Alabama, and abandoning him there. Nothing more is required to establish specific jurisdiction.[28]

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[28]Even if the facts alleged in the Complaint were inadequate as to one or more of the three prongs of the specific jurisdiction test, the Court finds that defendant has waived any such arguments by virtue of its failure to offer any substantive response to plaintiff's contention that defendant's in-state ambulance travel satisfies the prerequisites for specific jurisdiction. This Court will not speculate as to how NMMC might have combated the specific jurisdiction theory had it

Having ascertained that NMMC possesses the requisite minimum contacts with Alabama, the undersigned now turns to the second element of the due process inquiry, to-wit: whether asserting personal jurisdiction over NMMC would comport with traditional notions of fair play and substantial justice. *Carrillo*, 115 F.3d at 1542.[29] There appears to be nothing intrinsically unfair or unjust about requiring a Mississippi hospital that engages in patient transport activities in Alabama to defend a lawsuit in this state relating to and arising from such activities. Stated differently, NMMC has minimum contacts with this forum, and is unable to meet its concomitant burden "to show that the imposition of jurisdiction in the forum is unreasonable." *Ruiz de Molina*, 207 F.3d at 1358. Indeed, defendant offers no evidence that it will incur any meaningful burden in defending this action in a neighboring state, much less that any such burden outweighs the interests of Morgan and Alabama in having this dispute resolved here. Even if defendant had demonstrated hardship, which it has not, the fact remains that "[w]hen minimum contacts have been established, often the interests of the plaintiff and the forum will justify even the serious burdens placed on the alien defendant." *Vermeulen*, 985 F.2d at 1551 (citations omitted).

For all of the foregoing reasons, the Court finds that

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endeavored to do so.

[29]The "fair play and substantial justice" analysis hinges on such factors as "the burden on the defendant in defending the lawsuit, the forum state's interest in adjudicating the dispute, the plaintiff's interest in obtaining convenient and effective relief, the interstate judicial system's interest in obtaining the most efficient resolution of controversies and the shared interest of the states in furthering fundamental substantive social policies." *Horn v. Effort Shipping Co., Ltd.*, 777 F. Supp. 927, 931 (S.D. Ala. 1991) (citations omitted).

the exercise of personal jurisdiction over NMMC in this forum may be achieved without infringing on its due process rights or implicating the Alabama long-arm statute. On that basis, the Motion to Dismiss is **denied** insofar as it rests on a Rule 12(b)(2) personal jurisdiction argument.

B. Venue.

As a secondary position, NMMC maintains that this action should be dismissed for improper venue, pursuant to Rule 12(b)(3), Fed.R.Civ.P. Defendant's Motion invokes 28 U.S.C. § 1391(b), and will therefore be assessed according to that statute's standards for improper venue, rather than the framework set forth in 28 U.S.C. § 1404(a) for inconvenient venue.[30] Under § 1391(b), venue in a civil case wherein jurisdiction is not based solely on diversity is proper in any of the following locations:

> "(1) a judicial district where any defendant resides, if all defendants reside in the same State, (2) a judicial district in which a substantial part of the events or omissions giving rise to the claim occurred ..., or (3) a judicial district in which any defendant may be found, if there is no district in which the action may otherwise be brought."

Id. Because the face of the Complaint demonstrates that

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[30]In the course of its argument that venue is improper, NMMC protests that this forum "will prove to be unreasonable and inconvenient" and that most "staff, witnesses and records related to the screening and treatment decision that gave rise to this claim will be found in Mississippi." (Reply Brief, at 9.) Such arguments might resonate in the *forum non conveniens* context of § 1404(a); however, they are not relevant to the legal issue raised by NMMC, to-wit: whether venue is properly laid in this District Court pursuant to § 1391(b).

neither (1) nor (3) are satisfied here, the propriety of this District Court as a venue for the instant dispute turns on whether a substantial part of the events giving rise to Morgan's claims took place in this judicial district.

NMMC asserts that no substantial portion of the events occurred in Alabama. According to NMMC, "[t]he essential elements of the claim examine the initial screening and stabilization treatment," both of which occurred in Mississippi. (Reply Brief, at 10.) The transfer of Mr. Morgan to Alabama, NMMC states, "pales in comparison to 8 days of care given in Mississippi." (*Id.*) This line of argument – that venue does not lie in Alabama because the most substantial events took place in Mississippi – misapprehends the governing legal standard.

The venue statute "contemplates some cases in which venue will be proper in two or more districts." *Jenkins Brick Co. v. Bremer*, 321 F.3d 1366, 1371 (11th Cir. 2003); *see also Mitrano v. Hawes*, 377 F.3d 402, 405 (4th Cir. 2004) ("Under the amended statute, it is possible for venue to be proper in more than one judicial district."); Wright & Miller, *Federal Practice and Procedure* § 3806 (explaining that "it is now absolutely clear that there can be more than one district in which a substantial part of the events giving rise to the claim occurred"); 28 U.S.C. § 1391, Commentary on 1988 and 1990 Revisions ("there may be several districts that qualify as a situs of such 'substantial' activities"). Indeed, under § 1391 a plaintiff does not have to select the venue with the most substantial nexus to the dispute, as long as she chooses a venue where a substantial part of the events giving rise to the claim occurred. *See Country Home Products, Inc. v. Schiller-Pfeiffer, Inc.*, 350 F. Supp.2d 561, 568 (D. Vt. 2004) (explaining that "the plaintiff is not required to establish that his chosen venue has the most substantial contacts to the dispute; rather, it is sufficient that a substantial part of the events occurred [here], even if a greater part of the events occurred elsewhere"); *Greenblatt v. Gluck*, 265 F. Supp.2d 346, 352 (S.D.N.Y. 2003) (similar);

TruServ Corp. v. Neff, 6 F. Supp.2d 790, 792 (N.D. Ill. 1998) ("The test is not whether a majority of the activities pertaining to the case were performed in a particular district, but whether a substantial portion of the activities giving rise to the claim occurred in the particular district."). Thus, the question confronting the undersigned is not whether the lion's share of the events at issue occurred in the Southern District of Alabama, nor is it the relative magnitude and significance of the events occurring in this judicial district as compared to those in the Northern District of Mississippi. Instead, the question is simply whether "a substantial part" of the events transpired here.

In evaluating whether events or omissions support venue under § 1391(b), the Eleventh Circuit has made clear that "[o]nly the events that directly give rise to a claim are relevant" and that "only those acts and omissions that have a close nexus to the wrong" are properly weighed in the "substantial part" analysis. *Jenkins Brick*, 321 F.3d at 1372; *see also Daniel v. American Bd. of Emergency Medicine*, 428 F.3d 408 (2nd Cir. 2005) ("When material acts or omissions within the forum bear a close nexus to the claims, they are properly deemed significant and, thus, substantial, but when a close nexus is lacking, so too is the substantiality necessary to support venue.").[31] In that regard, the Court finds a close nexus between the alleged acts and omissions of NMMC in the Southern District of Alabama and the claims asserted by Morgan in this lawsuit. The gravamen of plaintiff's claims is

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[31]This philosophy has not been embraced by all appellate courts in interpreting the "substantial part" language. *See, e.g., Mitrano*, 377 F.3d at 405 (citing First and Sixth Circuit authorities for proposition that "in determining whether events or omissions are sufficiently substantial to support venue under the amended statute, a court should not focus only on those matters that are in dispute or that directly led to the filing of the action," but instead "should review the entire sequence of events underlying the claim").

that the Hospital admitted Mr. Morgan under false pretenses, failed to stabilize his emergency medical condition, then shipped him via Hospital ambulance to his home in this judicial district, where he died a short time later. The legal elements of the alleged EMTALA violation may have been satisfied the moment that NMMC wheeled Mr. Morgan out the front door of the Hospital and into a waiting ambulance. Nonetheless, NMMC's alleged act of transporting him to and leaving him in Alabama bear a "close nexus" to the alleged wrong under any reasonable construction of the term, from a logical, temporal and sequential vantage point. Moreover, plaintiff will undoubtedly rely heavily on the Alabama events to prove that Mr. Morgan was "transferred" for EMTALA purposes without prior stabilization of his emergency medical condition, inasmuch as his rapid decline upon being left in his home might support an inference that the Hospital failed to stabilize him (within the statutory meaning of the term) before discharging him. Thus, the Alabama occurrences may figure prominently in the proof at trial. On that basis, the undersigned is of the opinion that venue properly lies in this judicial district. Defendant's Motion to Dismiss for improper venue is therefore **denied** pursuant to 28 U.S.C. § 1391(b)(2) and *Jenkins Brick*.[32]

C. Viability of EMTALA Cause of Action.

Defendant's third and final ground for relief is that plaintiff's EMTALA claim fails to state a claim upon which

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[32]In reaching this determination, the Court notes that defendant failed to offer any legal authority or analysis in support of its conclusory suggestion that NMMC's ambulance transportation of Mr. Morgan into Alabama does not qualify as a "substantial part" of the events. Instead, defendant simply argued that the events in Alabama were less critical or important than those events occurring in Mississippi. Such a relativist argument is unilluminating and unhelpful in applying the *Jenkins Brick* framework.

relief can be granted, such that dismissal is warranted pursuant to Rule 12(b)(6), Fed.R.Civ.P. The Court disagrees, at least in part.

1. Legal Standard for Rule 12(b)(6) Motion.

On a motion to dismiss, the Court must view the complaint in the light most favorable to the plaintiff. *Jenkins v. McKeithen*, 395 U.S. 411, 421-22, 23 L. Ed. 2d 404, 89 S. Ct. 1843 (1969). A motion to dismiss may be granted only where "it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45-46, 2 L. Ed. 2d 80, 78 S. Ct. 99 (1957); *Bradberry v. Pinellas County*, 789 F.2d 1513, 1515 (11th Cir. 1986). The rules of pleading require only that a complaint contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Rule 8(a), Fed.R.Civ.P. Moreover, the Court must, "at this stage of the litigation, . . . accept [plaintiff's] allegations as true." *Hishon v. King & Spalding*, 467 U.S. 69, 73, 81 L. Ed. 2d 59, 104 S. Ct. 2229 (1984); *Stephens v. HHS*, 901 F.2d 1571, 1573 (11th Cir. 1990); *cf. South Florida Water Management Dist. v. Montalvo*, 84 F.3d 402, 409 n.10 (11th Cir. 1996) (conclusory allegations and unwarranted deductions of fact are not deemed true on a motion to dismiss). The Court's inquiry at this stage focuses on whether the challenged pleadings "give the defendant fair notice of what the plaintiff's claim is and the grounds upon which it rests." *Conley*, 355 U.S. at 47. A plaintiff must meet only an "exceedingly low" threshold to withstand a Rule 12(b)(6) motion. *United States v. Baxter Int'l, Inc.*, 345 F.3d 866, 881 (11th Cir. 2003).

2. Overview of EMTALA.

EMTALA is a federal anti-dumping provision that was enacted in 1986 for the stated purpose of preventing "patient dumping," which is "the practice of some hospital

emergency rooms turning away or transferring indigents to public hospitals without prior assessment or stabilization treatment." *Harry v. Marchant*, 291 F.3d 767, 772 (11th Cir. 2002) (*en banc*); *see also Hunt ex rel. Hunt v. Lincoln County Memorial Hosp.*, 317 F.3d 891, 893 n.5 (8th Cir. 2003) ("This law was enacted to address patient 'dumping' by hospitals of patients without the appropriate amount of insurance."); *Holcomb v. Monahan*, 30 F.3d 116, 117 n.2 (11th Cir. 1994) ("Congress enacted EMTALA to prevent 'patient dumping' (the practice whereby private hospital emergency rooms refuse to treat indigent patients by transferring them to public hospitals or turning them away)."). Courts have universally recognized that EMTALA was not conceived as a federal medical malpractice statute. *See, e.g., Nolen v. Boca Raton Community Hosp., Inc.*, 373 F.3d 1151, 1154 (11th Cir. 2004); *Harry*, 291 F.3d at 770; *Hunt*, 317 F.3d at 894; *Jakubiec v. Sacred Heart Health System, Inc.*, 2005 WL 1261443, *2 (N.D. Fla. May 27, 2005); *Bowden ex rel. Bowden v. Wal-Mart Stores, Inc.*, 2001 WL 617521, *4 n.4 (M.D. Ala. Feb. 20, 2001); *Gardner v. Elmore Community Hosp.*, 64 F. Supp.2d 1195, 1201 (M.D. Ala. 1999).

EMTALA requires hospitals to satisfy two distinct obligations, which are commonly labeled as the "appropriate medical screening requirement" and the "stabilization requirement." *Harry*, 291 F.3d at 770. Pursuant to the former duty, if an individual comes to a hospital's emergency department and requests examination or treatment of a medical condition, "the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department ... to determine whether or not an emergency medical condition ... exists." 42 U.S.C. § 1395dd(a). Under the latter, if an individual comes to a hospital and the hospital determines that person to have an emergency medical condition, then the hospital must either provide "such further medical examination and such treatment as may be required to stabilize the medical condition" or "transfer ... the individual

to another medical facility" in accordance with EMTALA requirements. 42 U.S.C. § 1395dd(a); *see also Harry*, 291 F.3d at 770 (characterizing stabilization requirement as mandating that hospital provide stabilization treatment before transferring patient with an emergency condition). Morgan's EMTALA claim purports to allege violations of both statutory requirements.[33]

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[33]As a threshold matter, MMNC argues that EMTALA "applies only to persons who present to hospital emergency departments." (Motion, ¶ 4.) In support of this contention, defendant relies heavily on *Lopez-Soto v. Hawayek*, 175 F.3d 170 (1st Cir. 1999). But *Lopez-Soto* actually stands for a proposition dramatically different than that ascribed to it by defendant. In *Lopez-Soto*, the First Circuit declared that, while the screening requirement is limited to emergency departments, the stabilization requirement "unambiguously imposes certain duties on covered hospitals vis-a-vis *any* victim of a detected medical emergency, regardless of how that person enters the institution or where within the walls he may be when the hospital identifies the problem." *Id.* at 173; *see also* 42 U.S.C. § 1395dd(b) (imposing stabilization requirement whenever individual "comes to a hospital and the hospital determines that the individual has an emergency medical condition," with no textual limitation to emergency departments). *Lopez- Soto* reasoned that the broad sweep of the stabilization requirement makes sense because "stabilization is arguably the key to ensuring the health of those already admitted to the hospital who develop emergency medical conditions." 175 F.3d at 175. When the defendant asserted (as does NMMC here) that interpreting the stabilization requirement so expansively would do violence to the legislative purpose of EMTALA to clamp down on patient dumping, *Lopez-Soto* rebuffed this objection by reasoning that "patient dumping is not a practice that is limited to emergency rooms," and that dumping admitted patients who develop emergency conditions "is equally as pernicious as what occurs in emergency departments, and we are unprepared to say that Congress did not seek to curb it." *Id.* at 177. Thus, NMMC's

3. The Appropriate Medical Screening Requirement.

Plaintiff maintains that the Hospital failed to comply with the screening requirement of EMTALA "by failing to obtain an MRI scan of Mr. Morgan's back . . . to determine that an emergency medical condition existed in the thoracic region of his spine" on August 30, 2003. (Complaint, ¶ 17.) Neither the Complaint nor plaintiff's submission as to the Motion to Dismiss supplies further amplification of the screening aspect of her EMTALA claim.

Review of pertinent case authorities confirms that EMTALA's medical screening requirement is far too narrow to sustain plaintiff's claim. Contrary to plaintiff's contention, the screening duty is not triggered whenever a hospital neglects to perform a screening test that the plaintiff believes should have been done, or even one that any reasonably diligent hospital would have performed. Rather, EMTALA's screening obligation is focused exclusively on ensuring that a hospital applies the same screening procedures for indigent patients who present at its emergency room that it does for similarly situated patients who have insurance or are otherwise well-heeled. *See, e.g.*, *Holcomb*, 30 F.3d at 117 (explaining that statute's appropriate medical screening requirement "only requires a hospital to provide indigent patients with a medical screening similar to one which they would provide any other patient").[34] Simply put, "[a]s long as

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attempt to confine all EMTALA obligations to emergency departments results from an incorrect reading of the statute and the caselaw.

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A veritable avalanche of appellate and district court authority in this Circuit confirms the validity of that interpretation of § 1395dd(a). *See Nolen*, 373 F.3d at 1155 ("So long as the Hospital

a hospital applies the same screening procedures to indigent patients which it applies to paying patients, the hospital does not violate" the screening section of EMTALA. *Holcomb*, 30 F.3d at 117. Thus, failing to perform even a medically advisable screening test in no way implicates EMTALA unless the Hospital treated Mr. Morgan differently in that regard than it would have treated a similarly situated paying patient. *See Hunt*, 317 F.3d at 894 (affirming dismissal of EMTALA screening claim where plaintiff's claim was not that he received nonuniform treatment, but that he received incorrect treatment).[35]

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gave to [the plaintiff] the same quality screening that it would have given a similarly situated outpatient, there is no violation of the EMTALA."); *Jakubiec*, 2005 WL 1261443, at *2 (following *Holcomb* and *Nolen*); *Williamson v. Roth*, 120 F. Supp.2d 1327, *1333 (M.D. Fla. 2000) ("As long as a hospital applies the same screening procedures to indigent patients which it applies to paying patients, the hospital does not violate this section of EMTALA."); *see also Gardner*, 64 F. Supp.2d at 1201 (hospital satisfies EMTALA's screening requirement if "it utilizes identical screening procedures for all patients complaining of the same condition or exhibiting the same symptoms").

[35]As one district court cogently and correctly observed, "[t]he essence of this requirement is that there be some screening procedure, and that it be administered even-handedly. Therefore, a refusal to follow regular screening procedures in a particular instance contravenes the statute, but faulty screening, in a particular case, as opposed to disparate screening or refusing to screen at all, does not contravene the statute." *Gardner*, 64 F. Supp.2d at 1202; *see also Summers v. Baptist Medical Center Arkadelphia*, 91 F.3d 1132, 1138 (8th Cir. 1996) ("Patients are entitled under EMTALA, not to correct or non-negligent treatment in all circumstances, but to be treated as other similarly situated patients are treated, within the hospital's capabilities. It is up to the hospital itself to determine what its screening procedures will be. Having done

The Complaint is devoid of any suggestion that the Hospital engaged in disparate treatment of Mr. Morgan vis a vis insured customers, or that it violated its own screening protocols in neglecting to give him an MRI; rather, the crux of the "screening" portion of the claim is simply that Mr. Morgan needed an MRI, but the Hospital failed to provide one for him. This aspect of plaintiff's EMTALA claim bears the unmistakable tincture of a malpractice or negligence claim in disguise. As demonstrated by the foregoing authorities, such a theory, not rooted in any disparate treatment formulation, is not cognizable under EMTALA. Even if Morgan had properly alleged a theory of disparate treatment sufficient to invoke the appropriate medical screening requirement (which she has not), this obligation is inapplicable here because § 1395dd(a) is confined on its face to Hospital emergency departments. The statute itself restricts the screening obligation to circumstances where an individual "comes to the emergency department," and requires "an appropriate medical screening examination ***within the capability of the hospital's emergency department***." 42 U.S.C. § 1395dd(a) (emphasis added). This language is bolstered by appellate decisions that have limited the screening requirement to the emergency room setting. *See Harry*, 291 F.3d at 770 ("The appropriate medical screening requirement obligates hospital emergency rooms to provide an appropriate medical screening ...."); *Lopez-Soto v. Hawayek*, 175 F.3d 170, 173 (1st Cir. 1999) (construing § 1395dd(a) as "obligat[ing] hospitals to screen only those individuals who present themselves at the emergency department"). The Court's research has disclosed no authorities, and plaintiff has cited none, in which EMTALA's screening duty has been extended to an inpatient some eight days post- admission to the hospital. Inasmuch as such a construction of the statute would contravene its express language and does not appear to be supported by any

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so, it must apply them alike to all patients.").

interpretive case law, this Court declines to engraft EMTALA's screening duty to encompass a hospital's failure to perform certain desired tests more than a week after a patient is admitted for treatment.

In short, plaintiff's contention that the Hospital should have performed an MRI on Mr. Morgan's back on August 30, 2003, some eight days after his admission, may well be actionable through various state law vehicles. It is not, however, in violation of EMTALA's screening requirements, inasmuch as: (a) plaintiff has not alleged that the Hospital treated Mr. Morgan differently than similarly situated insured patients in that regard; and (b) even if such an allegation had been made, the screening requirement is limited to emergency rooms and does not extend to other, non-emergency departments of a hospital post-admission of a patient. Therefore, the Court finds that plaintiff's EMTALA claim is actionable, if at all, only on a failure to stabilize theory, not on a failure to perform appropriate medical screening.

4. The Stabilization Requirement.

The Complaint also alleges that NMMC failed to comply with EMTALA's stabilization requirement, asserting that the Hospital "failed to provide the medical treatment necessary to stabilize Mr. Morgan and, further, discharged him in an unstable medical condition." (Complaint, ¶ 18.) Plaintiff argues that these allegations plead a violation of EMTALA, which requires a hospital, when it becomes aware of an individual's emergency medical condition, to provide "such further medical examination and such treatment as may be required to stabilize the medical condition." 42 U.S.C. § 1395dd(b)(1)(A).[36] The statute defines the term "stabilize"

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[36]The statute also provides that, as an alternative to stabilization, a hospital may transfer a patient to another medical facility under certain circumstances (*i.e.*, a patient's

as requiring such treatment of an emergency medical condition "as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility." *Id.* § 1395dd(e)(3)(A); *see also Bowden ex rel. Bowden v. Wal-Mart Stores, Inc.*, 124 F. Supp.2d 1228, 1237 (M.D. Ala. 2000) ("A patient's condition is stabilized if no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual.") (citing *Cherukuri v. Shalala*, 175 F.3d 446, 450 (6th Cir. 1999)). "Transfer" is also a term of art in EMTALA. It is not confined to inter-hospital patient swaps, but is instead defined as "the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by ... the hospital." 42 U.S.C. § 1395dd(e)(4).

Construing these statutory provisions in unison reveals that § 1395dd(b) is violated if a hospital discharges a patient with knowledge of his emergency medical condition and without engaging in such medical examination and treatment as may be necessary to assure that no material deterioration of the patient's condition will likely result from such discharge. The case law is consistent with this construction. For example, one district court has opined that "a viable Section 1395dd(b) claim requires plaintiffs to plead that: (1) they had an emergency medical condition; (2) the hospital knew of the condition; and (3) the patient was not stabilized before being discharged or transferred." *Kizzire v. Baptist Health Systems, Inc.*, 343 F. Supp.2d 1074, 1084 (N.D. Ala. 2004); *see also Williamson v. Roth*, 120 F. Supp.2d 1327, 1334 (M.D. Fla. 2000) ("Section 1395dd(b) of

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informed written request to be transferred, certification by a physician or other qualified medical person that the medical benefits of transfer outweigh patient risks, etc.). That provision of EMTALA is not at issue here.

EMTALA requires that after a hospital determines that a patient is experiencing an 'emergency medical condition' it must provide 'whatever treatment, within its capabilities, is needed to stabilize the condition before transferring or discharging the patient.'"). The Eleventh Circuit has emphasized that "the triggering mechanism for stabilization treatment under EMTALA is transfer," which plainly includes discharge. *Harry*, 291 F.3d at 772.

NMMC contends that the nine-day interval between Mr. Morgan's arrival at the Hospital and his discharge places this case outside the temporal parameters of the stabilization requirement. (Motion, ¶ 4.) But nothing in § 1395dd(b) would restrict the scope of the stabilization requirement to a maximum number of minutes, hours or days after a person with an emergency medical condition presents at a hospital. To be sure, some courts in other jurisdictions have soldered judicially-crafted limitations onto this requirement; however, others have declined to do so. The Eleventh Circuit appears never to have entered this fray, but research canvassing appellate decisions on this question identifies three distinct approaches. The Fourth Circuit has imputed a fuzzy, ill-defined temporal limitation on all § 1395dd(b) claims, such that the stabilization requirement is confined to "the hospital's care of the patient only in the immediate aftermath of the act of admitting her for emergency treatment and while it considered whether it would undertake longer-term full treatment or instead transfer the patient." *Bryan v. Rectors and Visitors of University of Virginia*, 95 F.3d 349, 352 (4th Cir. 1996) (holding that EMTALA was not violated where patient had been admitted to hospital for 12 days, during which time she received stabilizing treatment). The *Bryan* approach is unsatisfying because (a) by effectively limiting the stabilization duty to emergency departments, it seemingly disregards statutory language extending the stabilization requirement to entire hospitals but limiting the screening requirement to emergency departments; (b) the undersigned would have no idea how to apply the nebulous "immediate aftermath" concept to a specific set of facts; (c) the

"immediate aftermath" constraint was cut from whole cloth by the appellate court, and lacks any underpinnings in the statute or its accompanying regulations; and (d) such a holding suggests that hospitals could receive a "free pass" from EMTALA liability simply by admitting patients whom they had no intention of treating, then unscrupulously dumping them a short time later by discharging them without providing necessary stabilizing treatment. Thus, far from vindicating the statutory purposes, *Bryan* appears to conflict with them by imbuing admission with talismanic significance as a "cure-all" that guarantees freedom from EMTALA liability, regardless of what chicanery a hospital might engage in post-admission to unload an indigent, unprofitable patient with an emergency health condition.

On the other end of the spectrum, the Sixth Circuit has endorsed a position that EMTALA's stabilization requirements can apply well after the patient is admitted to a hospital. In *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131 (6th Cir. 1990), the panel interpreted § 1395dd(b) as meaning that "once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room." *Id.* at 1134. The *Thornton* court expressed concern that if the law were otherwise, hospitals might circumvent EMTALA by admitting emergency room patients then immediately discharging them. On that basis, the Sixth Circuit refused to draw a black-line distinction between emergency room care and inpatient care for purposes of the stabilization requirement, but instead construed EMTALA as creating a blanket requirement that "[e]mergency care must be given until the patient's emergency medical condition is stabilized," whenever and wherever that might occur. *Id.* at 1135; *see generally Lopez-Soto,* 175 F.3d at 175 (interpreting stabilization requirement as "obligating hospitals to stabilize individuals (wherever in the hospital they may be) when emergency medical conditions are detected," with no clear temporal constraint). This approach also seems vulnerable to

abuse, inasmuch as it would allow for an open-ended, uncabined duration of the stabilization requirement with no logical limiting principle. Under this line of reasoning, then, the stabilization duty could be imputed as extending indefinitely after a patient's admission and potentially poaching on regulatory territory patrolled by state malpractice law, an outcome which runs directly counter to the stated purpose of EMTALA. *See Lopez-Soto*, 175 F.3d at 177 n.4 ("If stabilization were mandated by EMTALA without limit of time, it might well encroach upon the province of state malpractice law.").

If the Fourth Circuit's construction of the temporal limits of § 1395dd(b) is too draconian, and if the Sixth Circuit's is too permissive, then, much like Goldilocks in the famed fairy tale, the Ninth Circuit's approach may be just right. In *Bryant v. Adventist Health Systems/West*, 289 F.3d 1162 (9th Cir. 2002), the court weighed both the Fourth and Sixth Circuit alternatives before holding "that EMTALA's stabilization requirement ends when an individual is admitted for inpatient care." *Id.* at 1168. Lest one conclude that the *Bryant* court merely aped the Fourth Circuit's *Bryan* decision, the Ninth Circuit tempered this holding by recognizing the wisdom of the Sixth Circuit's concern that a hospital might attempt to evade EMTALA liability by admitting a patient under false pretenses to cut off his stabilization rights, then unceremoniously dumping him as soon as the coast was clear. In that regard, *Bryant* added an important caveat to its inpatient rule, stating that "[i]f a patient demonstrates in a particular case that inpatient admission was a ruse to avoid EMTALA's requirements, then liability under EMTALA may attach," notwithstanding such admission. *Id.* at 1169; *see also Mazurkiewicz v. Doylestown Hosp.*, 305 F. Supp.2d 437, 447 (E.D. Pa. 2004) ("the most persuasive synthesis of the law on admission as a defense to EMTALA liability is that admission is a defense

so long as admission is not a subterfuge").[37]

The undersigned is of the opinion that the rule announced by the Ninth Circuit in *Bryant* most accurately captures the letter and spirit of EMTALA and its attendant regulations, while also remedying the inherent defects in the Fourth and Sixth Circuit constructions of § 1395dd(b). In light of these principles, and in the absence of any guidance from the Eleventh Circuit, the Court finds that the EMTALA obligation to stabilize a patient ceases at the time of the patient's admission as an inpatient, unless the hospital fails to admit the patient in good faith or does so as a subterfuge to avert EMTALA liability.

A fair reading of the Complaint supports a subterfuge theory of liability. Plaintiff alleges that the Hospital demanded that she make financial arrangements to pay for her husband's treatment immediately after his arrival at the emergency department, then announced its intention to discharge him the very next day, despite knowledge of the compression fractures of his thoracic vertebrae, his intense back pain, his inability to walk, his pulmonary contusions

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[37]The *Bryant* holding and its explicit limitation is echoed in the implementing regulations for EMTALA. Those regulations provide, in pertinent part, that "[i]f a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient ***in good faith*** in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities" under EMTALA. 42 CFR § 489.24(d)(2)(i) (emphasis added). This regulation confirms that admission of a patient cuts off a hospital's stabilization duty under EMTALA only if that patient has been admitted in good faith. Defendant quoted this regulation in its reply brief, but curiously omitted the critically important "in good faith" qualifier from the regulatory language. (*See* Reply Brief, at 2-3.)

and the blood in his lungs. These allegations, accepted as true for Rule 12(b)(6) purposes, could reasonably support a conclusion that the Hospital's admission of Mr. Morgan was a mere façade, a charade undertaken for risk management purposes even though the Hospital had no intention of stabilizing his injuries before transferring him. Of course, Morgan will be required to prove this subterfuge theory at trial by competent evidence. For now, however, she has adequately alleged a violation of § 1395dd(b) inasmuch as her Complaint states or fairly implies that: (a) Mr. Morgan presented at the Hospital for treatment of an emergency medical condition; (b) the Hospital had actual knowledge that Mr. Morgan had an emergency medical condition; (c) the Hospital admitted Mr. Morgan as an inpatient, but never intended to provide him stabilizing care; (d) the Hospital discharged Mr. Morgan without providing him such medical treatment of his emergency medical conditions as was necessary to assure, within reasonable medical probability, that no material deterioration of his condition was likely to result from or occur during his transfer from the Hospital; and (e) mere hours after the transfer was completed, Mr. Morgan died in his home from the emergency medical condition in question. Defendant's Motion to Dismiss is therefore **denied** as to the EMTALA stabilization claim.[38]

This conclusion is not altered by NMMC's attempt to recharacterize plaintiff's EMTALA stabilization cause of action as a concealed negligence or malpractice claim. (Motion, ¶ 6.) The Complaint alleges nothing of the sort. Rather, the EMTALA claim alleges that the Hospital discharged Mr. Morgan without stabilizing a known

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[38]Because the stabilization claim passes Rule 12(b)(6) muster, plaintiff's EMTALA claim confers upon the Court federal question jurisdiction pursuant to 28 U.S.C. § 1331. The requisite jurisdiction plainly exists, and defendant's argument that this action should be dismissed for want of subject matter jurisdiction is unfounded.

emergency medical condition. Such a theory of liability plainly sounds under § 1395dd(b), and presents a colorable claim under that statute notwithstanding defendant's attempts to relabel it as something else.

III. Conclusion.

For all of the foregoing reasons, the Motion to Dismiss (doc. 5) is **granted in part, and denied in part**. In particular, the Motion is **granted** as to the EMTALA claim predicated on violation of the appropriate medical screening requirement, and that aspect of Count One is **dismissed without prejudice**. In all other respects, the Motion is **denied**. The Court finds that the exercise of personal jurisdiction over NMMC is proper, that venue lies in this judicial district, and that federal subject matter jurisdiction is present.

DONE and ORDERED this 2nd day of December, 2005.

s/ WILLIAM H. STEELE
UNITED STATES DISTRICT JUDGE

APPENDIX E - ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT DATED AND DECIDED ON JULY 17, 2007 DENYING PETITIONER'S PETITION FOR REHEARING AND PETITION FOR REHEARING EN BANC.

IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 06-16017

BRENDA L. MORGAN,

Plaintiff-Appellant,

versus

NORTH MISSISSIPPI MEDICAL CENTER, INC.,

Defendant-Appellee.

Appeal from the United States District Court
for the Southern District of Alabama

ON PETITION(S) FOR REHEARING AND
PETITION(S) FOR REHEARING EN BANC

Before: EDMONDSON, Chief Judge, HULL, Circuit Judge, and FORRESTER,*

PER CURIAM:

The Petition for Rehearing is DENIED and no Judge in regular active service on the Court having requested that the Court be polled on reharing en banc (Rule 35, Federal Rules of Appellate Procedure), the Petition for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT:

UNITED STATES CIRCUIT JUDGE

* Honorable J. Owen Forrester, United States District Judge for the Northen District of Georgia, sitting by designation.

Appendix F - 42 U.S.C.A. §§ 1395dd

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR

(a) Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

(b) Necessary stabilizing treatment for emergency medical conditions and labor

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(A) within the staff and facilities

available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

(2) Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

(3) Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an

individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

(c) Restricting transfers until individual stabilized

(1) Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless--

(A)(i) the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,

(ii) a physician (within the meaning of

section 1395x(r)(1) of this title) has signed a certification that [FN1] based upon the information available at the time of trans er, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or

(iii) if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

(2) Appropriate transfer

An appropriate transfer to a medical facility is a transfer--

(A) in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;

(B) in which the receiving facility--

(i) has available space and qualified personnel for the treatment of the individual, and

(ii) has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(C) in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided

under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;

(D) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(E) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

(d) Enforcement

(1) Civil money penalties

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil money penalty of not more than $50,000 (or not more than $25,000 in the case of a hospital with less than 100 beds) for each such violation. The provisions of section 1320a-7a of this title (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner

as such provisions apply with respect to a penalty or proceeding under section 1320a-7a(a) of this title.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates a requirement of this section, including a physician who--

(i) signs a certification under subsection (c)(1)(A) of this section that the medical benefits reasonably to be expected from a transfer to another facility outweigh the risks associated with the transfer, if the physician knew or should have known that the benefits did not outweigh the risks, or

(ii) misrepresents an individual's condition or other information, including a hospital's obligations under this section,

is subject to a civil money penalty of not more than $50,000 for each such violation and, if the violation is gross and flagrant or is repeated, to exclusion from participation in this subchapter and State health care programs. The provisions of section 1320a-7a of this

title (other than the first and second sentences of subsection (a) and subsection (b)) shall apply to a civil money penalty and exclusion under this subparagraph in the same manner as such provisions apply with respect to a penalty, exclusion, or proceeding under section 1320a-7a(a) of this title.

(C) If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the hospital on its list of on-call physicians (required to be maintained under section 1395cc(a)(1)(I) of this title) and notifies the on-call physician and the on-call physician fails or refuses to appear within a reasonable period of time, and the physician orders the transfer of the individual because the physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer, the physician authorizing the transfer shall not be subject to a penalty under subparagraph (B). However, the previous sentence shall not apply to the hospital or to the on-call physician who failed or refused to appear.

(2) Civil enforcement

(A) Personal harm

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility

Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions

No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(3) Consultation with peer review organizations

In considering allegations of violations of the requirements of this section in imposing sanctions under paragraph (1) or in terminating a hospital's participation under this subchapter, the Secretary shall request the appropriate utilization and quality control peer review organization (with a contract under part B of subchapter XI of this chapter) to assess whether the individual involved had an emergency medical condition which had not been stabilized, and provide a report on its findings. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall request such a review before effecting a sanction under paragraph (1) and shall provide a period of at least 60 days for such review. Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this subchapter for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's

report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B of subchapter XI of this chapter.

(4) Notice upon closing an investigation

The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.

(e) Definitions

In this section:

(1) The term "emergency medical condition" means--

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant woman who is having contractions--

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

(2) The term "participating hospital" means a hospital that has entered into a provider agreement under section 1395cc of this title.

(3)(A) The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).

(B) The term "stabilized" means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual

from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).

(4) The term "transfer" means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(5) The term "hospital" includes a critical access hospital (as defined in section 1395x(mm)(1) of this title).

(f) Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

(g) Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an

individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(h) No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

(i) Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

CREDIT(S)

(Aug. 14, 1935, c. 531, Title XVIII, §§ 1867, as added Apr. 7, 1986, Pub.L. 99-272, Title IX, §§ 9121(b), 100 Stat. 164, and amended Oct. 21, 1986, Pub.L. 99-509, Title IX, §§ 9307(c)(4), 100 Stat. 1996; Oct. 22, 1986, Pub.L. 99-514, Title XVIII, §§ 1895(b)(4), 100 Stat. 2933; Dec. 22, 1987, Pub.L. 100-203, Title IV, §§

4009(a), 101 Stat. 1330-56, 1330-57; Dec. 22, 1987, Pub.L. 100-203, Title IV, §§ 4009(a)(1), formerly §§ 4009(a)(1), (2), 101 Stat. 1330-56, 1330-57; renumbered and amended July 1, 1988, Pub.L. 100-360, Title IV, §§ 411(b)(8)(A)(i), 102 Stat. 771; Oct. 13, 1988, Pub.L. 100-485, Title VI, §§ 608(d)(18)(E), 102 Stat. 2419; Dec. 19, 1989, Pub.L. 101-239, Title VI, §§§§ 6003(g)(3)(D)(xiv), 6211(a) to (h), 103 Stat. 2154, 2245; Nov. 5, 1990, Pub.L. 101-508, Title IV, §§§§ 4008(b)(1) to (3)(A), 4207(a)(1)(A), (2), (3), (k)(3), 104 Stat. 1388-44, 1388-117, 1388-124; renumbered and amended Oct. 31, 1994, Pub.L. 103-432, Title I, §§ 160(d)(4), (5)(A), 108 Stat. 4444; Aug. 5, 1997, Pub.L. 105-33, Title IV, §§ 4201(c)(1), 111 Stat. 373; Dec. 8, 2003, Pub.L. 108-173, Title VII, §§ 736(a)(14), Title IX, §§ 944(b), (c)(1), 117 Stat. 2355, 2423.)

[FN1] So in original. Probably should be followed by a comma.

Appendix G - 67 FR 31404

PROPOSED RULES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 412, 413, 482, 485, and 489

[CMS-1203-P]

RIN 0938-AL23

Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems

and Fiscal Year 2003 Rates

Thursday, May 9, 2002

*31404 AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: We are proposing to revise the Medicare acute care hospital inpatient prospective payment systems for operating and capital costs to implement changes arising from our continuing experience with these systems. In addition, in the Addendum to this proposed rule, we describe the proposed changes to the amounts and factors used to determine the rates for Medicare hospital inpatient services for operating

costs and capital-related costs. These changes would be applicable to discharges occurring on or after October 1, 2002. We also are setting forth proposed rate-of-increase limits as well as proposed policy changes for hospitals and hospital units excluded from the acute care hospital inpatient prospective payment systems.

In addition, we are proposing changes to other hospital payment policies, which include policies governing: payments to hospitals for the direct and indirect costs of graduate medical education; pass-through payments for the services of nonphysician anesthetists in some rural hospitals; clinical requirements for swing-bed services in critical access hospitals (CAHs); payments to provider-based entities; and implementation of the Emergency Medical Treatment and Active Labor Act (EMTALA).

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9. Scope of EMTALA Applicability to Hospital Inpatients

While most issues regarding EMTALA arise in connection with ambulatory patients, questions have occasionally been raised about whether EMTALA applies to inpatients. In late 1998, the United States Supreme Court considered a case (Roberts v. Galen of Virginia) that involved, in part, the question of whether EMTALA applies to inpatients in a hospital. In the context of that case, the United States

Solicitor General advised the Supreme Court that the Department of Health and Human Services (DHHS) would develop a regulation clarifying its position on that issue. After reviewing the issue in the light of the EMTALA statute, we are proposing that EMTALA would apply to inpatients only under limited circumstances, as described in the following paragraphs.

As noted earlier, once a hospital has incurred an EMTALA obligation with respect to an individual, that obligation continues while the individual remains at the hospital, so that any transfer to another medical facility or discharge of the individual must be in compliance with the rules restricting transfer until the individual is stabilized under existing §§ 489.24(d). In many cases, medical judgment will dictate that a patient be admitted to the hospital for further treatment on an inpatient basis because the patient's emergency medical condition has not yet been stabilized.

In these cases, the hospital continues to be obligated under section 1867, irrespective of the inpatient admission. Admitting an individual whose emergency medical condition has not been stabilized does not relieve the hospital of further responsibility to the individual under this section. An individual's emergency medical condition will be considered to have been stabilized only when the criteria in §§ 489.24(b) are met; that is, the individual's condition must be such that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during a transfer of the individual from the facility or, if the patient is

a pregnant woman who is having contractions, that the woman has delivered the child and the placenta. Consistent with the above policy, we emphasize that an admission to inpatient status cannot be used to evade EMTALA responsibilities. Indeed, permitting inpatient admission to end EMTALA obligations would provide an obvious means of circumventing these requirements that would seemingly contradict the point of the statute to protect emergency patient health and safety. This point should be particularly evident in the case of a woman in labor, a central focus of the statute. Such women are frequently admitted, and the statute clearly contemplated protecting them until completion of the delivery (that is, stabilization). In addition, if an inpatient who had been admitted from the dedicated emergency department with an unstabilized emergency medical condition was never stabilized as an inpatient and is transferred, we would still apply EMTALA in reviewing the transfer. In this context, stability for transfer reflects a complex medical judgment that can be made only based on review of all relevant information in each particular case, including all conditions that could cause the patient to be medically unstable. A patient who goes in and out of apparent stability with sufficient rapidity or frequency would not be considered "stabilized" within the meaning of §§ 489.24; transient stability of such a patient does not relieve the hospital of its EMTALA obligation. Such a patient would continue to be covered by EMTALA until the patient's overall medical stability with respect to all conditions is achieved.

Except for the limited circumstances described above, we are proposing to clarify that EMTALA does not apply to hospital inpatients. We believe EMTALA does not apply to hospital inpatients because we interpret section 1867 of the Act by reading the statutory language as a whole, with the requirements of paragraphs (b), "Necessary Stabilizing Treatment for Emergency Medical Conditions and Labor," and (c), "Restricting Transfer Until Individual is Stabilized," applying only to those individuals who satisfy the threshold requirement of coming to the hospital and requesting emergency care (as interpreted in this proposed regulation). This interpretation is based upon the statutory language and the legislative history. First, the Congress defined "emergency medical condition" at section 1867(e)(1) of the Act by referring solely to "acute symptoms," which are self-identified, and did not mention other potentially relevant indications, in particular, signs or objective data. "Signs" are observable findings that are identified or confirmed by a clinician based on examination and use of objective data (for example, physiologic measurements, x-ray results). When a patient's condition deteriorates in the inpatient setting, awareness of a situation potentially requiring emergency care is based on any symptoms, signs, and objective data, reflecting a situation that is not captured by the targeted definition at section 1867(e)(1) of the Act. If the Congress had intended EMTALA to apply to transfers at any time during an inpatient stay, it would not have used a definition of emergency medical condition that focuses exclusively

on symptoms and that uniquely defines the individual's status at the time of his or her initial presentation to the hospital, not his or her status as an inpatient. Furthermore, the definition of "appropriate transfer" in paragraph (c)(2) of section 1867 of the Act includes a variety of terms (observation, signs, symptoms, preliminary diagnosis) associated with patient information that is gathered at the initial stage of clinical intervention, when the course of treatment is just beginning. Thus, it would appear to be clear that the authors of this legislation understood the precise meanings of these clinical terms and utilized them accordingly. Further indication that Congress intended this result is the language in section 1867(b)(1)(A) of the Act (stabilization), which requires that the hospital provide "for such further medical examination" as necessary to stabilize. Congress' use of the word "further" acknowledges that there was some initial treatment that occurred in the emergency department. In addition, the legislative history of EMTALA is replete with references to the problem of individuals denied emergency medical care at hospital emergency rooms, whereas there is no explicit reference to similar problems faced by hospital inpatients. (See, for example, 131 Cong. Rec. 28.587 and 28.588 (1985)). When the Congress considered the need for EMTALA legislation, it noted that Medicare-participating hospitals were bound to meet hospital conditions of participation, but that no specific requirements then existed for appropriate treatment of emergency patients. (See H.R. Rept. No. 241 (I)(1985), reprinted in 1986 U.S.C.C.A.N. 579,

605.) Arguably, the Congress also considered other protections available to hospital inpatients (for example, private causes of action).

This interpretation that EMTALA was not intended to apply to transfers at any time during an inpatient's stay is further supported by the language of the appropriate transfer provisions of section 1867(c) of the Act. While that paragraph does refer to individuals at a*31476 "hospital," rather than individuals at an "emergency department," the same paragraph also makes reference to actions to be taken by "a physician * * * physically present in the emergency department." This explicit mention of a hospital emergency department, even in a paragraph that generally cites an individual at a " hospital," supports the view that EMTALA was not intended to apply to admitted inpatients who may become unstable subsequent to admission, but only to patients who initially come to the hospital's emergency department with an emergency medical condition, and only until the condition has been stabilized. Finally, we note that once a hospital admits an individual as a patient, that hospital has a variety of other legal, licensing, and professional obligations with respect to the continued proper care and treatment of such patients.

a. Admitted Emergency Patients. A related issue concerns whether a hospital may satisfy its EMTALA obligations to an admitted emergency inpatient only by effectuating an actual stable discharge or appropriate transfer. We are proposing to clarify that even when an admitted emergency patient is not actually transferred, a determination may be made

as to whether or not the patient has been stabilized such that he or she could be transferred at a certain point without likely material deterioration of the patient's condition, as defined in section 1867(e)(3)(B) of the Act. Under our proposed policy, if the admitted emergency patient could have been transferred as "stable" under the statute and the period of stability is documented by relevant clinical data in the patient's medical record, the hospital has satisfied its EMTALA obligation by meeting the statutory requirement of providing stabilizing treatment to the point of stability for transfer, and the hospital's obligation under EMTALA ends, even though the patient may remain in inpatient status at the hospital. If, after stabilization, the individual who was admitted as an inpatient again has an apparent decline of his or her medical condition, either as a result of the injury or illness that created the emergency for which he or she initially came to the dedicated emergency department or as a result of another injury or illness, the hospital must comply with the conditions of participation under 42 CFR Part 482, but has no further responsibility under EMTALA with respect to the individual.

We also note that, just because a hospital may stabilize a patient for purposes of ending its EMTALA obligation to that patient, this does not relieve the hospital of any further health and safety obligations as to that patient under the Medicare program. While they remain patients in that hospital, these patients are still protected by a number of Medicare health and safety standards (conditions of participation), as explained further

below. In addition, as explained above, nothing under EMTALA in any way changes a hospital's other legal, licensing, and professional obligations with respect to the continued proper care and treatment of its patients.

Example 4: A patient comes to Hospital C's emergency department and requests treatment for an emergency medical condition. The patient knows he has severe heart disease and his chest pains have become more frequent. The patient receives an appropriate medical screening examination and is found to have an emergency medical condition, as indicated by a pain pattern and EKG abnormalities consistent with unstable angina. Stabilizing treatment in the emergency department on an outpatient basis, consisting of oxygen, nitrates and heparin, is initiated.

After several hours of outpatient care, the emergency physician determines that the patient is still not stable for purposes of discharge to his home. The emergency physician concludes that the patient can be treated most effectively by being admitted to Hospital C where he is currently being treated as an outpatient. The patient is admitted as an inpatient for further treatment. The attending physician knows that patients with indications for coronary angioplasty are usually transferred to Hospital D in another city because Hospital D has specialized capabilities that are unavailable at admitting Hospital C. A trip to Hospital D typically requires 2 hours travel by ground ambulance. The physician determines that the patient is stable for purposes of this type of transfer; that is, such a transfer is not

likely to result in a material deterioration of the patient's condition, and documents relevant clinical data in the patient's medical record. Even though patients with this degree of coronary arterial disease and acute infarction risk are usually transferred, the patient opposes transfer and wants to remain in the local community. In accordance with the wishes of the patient and his family, the attending physician agrees to treat the patient in Hospital C while informing the patient of the risks involved.

Application: In this situation, the admitted patient is not stable for purposes of discharge to his home but the attending physician determined that the patient is stable for the type of transfer usually undertaken by Hospital C for patients with unstable angina considered for angioplasty. This stabilization, which is documented by relevant clinical data in the patient's medical record, ends Hospital C's EMTALA obligation to the patient, and that obligation would not be reinstated by any subsequent deterioration in the patient's condition.

We are proposing to redesignate paragraph (c) of §§ 489.24 as paragraph (d), and include these stabilization requirements under a new proposed §§ 489.2(d)(2). (Proposed redesignated paragraph (d) would be revised further as explained in section V.K.9.b. of this preamble.)

b. Admitted Elective (Nonemergency) Patients. Most hospital admissions do not consist of emergency cases. In most cases, a patient who comes to the hospital and requests admission does so to obtain elective (nonemergency) diagnosis or treatment for a medical condition. Questions have arisen, however,

as to whether a hospital would be bound under EMTALA in the situation in which an admitted nonemergency inpatient experiences a deterioration of his or her medical condition.

Under our interpretation of section 1867 of the Act as described above, we believe EMTALA was intended to provide protection to patients coming to a hospital to seek care for an emergency condition. Therefore, we believe that the EMTALA requirements do not extend to admitted nonemergency inpatients. These patients are protected by a number of the Medicare hospital conditions of participation, as explained further under section V.K.13. of this preamble. These patients are further protected by a hospital's other legal, licensing, and professional obligations with respect to the continued proper care and treatment of its patients.

We are proposing to also include these requirements under the proposed redesignated §§ 489.24(d)(2).

. . .

Appendix H - 68 FR 53222

RULES and REGULATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 413, 482, and 489

[CMS-1063-F]

RIN 0938-AM34

Medicare Program; Clarifying Policies Related to the Responsibilities of

Medicare-Participating Hospitals in Treating Individuals With Emergency Medical

Conditions

Tuesday, September 9, 2003

*53222 AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

. . .

IX. Scope of EMTALA Applicability to Hospital Inpatients (§§ 489.24(d)(2))

A. Background and Provisions of the Proposed Rule

While most issues regarding EMTALA arise in connection with ambulatory patients, questions have

occasionally been raised about whether EMTALA applies to inpatients. In late 1998, the United States Supreme Court considered a case (Roberts v. Galen of Virginia, 525 U.S. 249 (1999)) that involved, in part, the question of whether EMTALA applies to inpatients in a hospital. In the context of that case, the United States Solicitor General advised the Supreme Court that the Department of Health and Human Services (DHHS) would develop a regulation clarifying its position on that issue. After reviewing the issue in the light of the EMTALA statute, in the May 9, 2002 proposed rule (67 FR 31475), we proposed that EMTALA would apply to admitted emergency patients until they have been stabilized. As we noted in the proposed rule, once a hospital has incurred an EMTALA obligation with respect to an individual, that obligation continues while the individual remains at the hospital, so that any transfer to another medical facility or discharge of the individual must be in compliance with the rules restricting transfer until the individual is stabilized under existing §§ 489.24(d). In these cases, we stated that the hospital continues to be obligated under section 1867 of the Act, irrespective of the inpatient admission, and that an individual's emergency medical condition will be considered to have been stabilized only when the criteria in §§ 489.24(b) are met. That is, the individual's condition must be such that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during a transfer of the individual from the facility or, if the patient is a pregnant woman who is having contractions, that the

woman has delivered the child and the placenta. We believed that such a policy would provide protections under the statute to those patient populations that are most vulnerable--individuals who are experiencing emergency medical conditions (including women in labor who are admitted to the hospital).

In addition, we proposed to clarify in the proposed rule that an individual who goes in and out of apparent stability with sufficient rapidity or frequency would not be considered "stabilized" within the meaning of §§ 489.24; transient stability of such an individual does not relieve the hospital *53244 of its EMTALA obligation (67 FR 31475). We proposed that such an individual would continue to be covered by EMTALA until the individual's overall medical stability with respect to all conditions is achieved. Based on an analysis of the statute (sections 1867(b)(1)(A), (c)(2), and (e)(1) of the Act) and the legislative history (131 Cong. Rec. 28.587 and 28.588 (1985) and H.R. Rept. No. 241 (I)(1985), reprinted in 1986 U.S.C.C.A.N. 579, 605.), we explained why we believed that EMTALA continued to apply to admitted emergency patients until they have been stabilized or appropriately transferred.

For a detailed discussion of the proposed policy on the applicability of EMTALA to admitted patients with unstabilized emergency medical conditions, see the preamble to the May 9, 2002 proposed rule at 67 FR 31475.

In addition, except for the limited circumstances described above, we proposed to clarify that EMTALA does not apply to nonemergency hospital

inpatients. Most hospital admissions do not consist of emergency cases. In most cases, an individual who comes to the hospital and requests admission does so to obtain elective (nonemergency) diagnosis or treatment for a medical condition. We noted that once a hospital admits an individual as a patient, that hospital has a variety of other legal, licensing, and professional obligations with respect to the continued proper care and treatment of such patients. We proposed to redesignate paragraph (c) of §§ 489.24 as paragraph (d), and include stabilization requirements under a new proposed §§ 489.2(d)(2). (Proposed redesignated paragraph (d) was proposed to be revised further as explained in section V.K.9.b. of the preamble of the May 9, 2002 proposed rule (67 FR 31456).) In addition, we proposed to include the requirements for nonapplicability of EMTALA to nonemergency hospital inpatients under proposed redesignated §§ 489.24(d)(2).

B. Summary of Public Comments and Departmental Responses

1. Applicability of EMTALA to Inpatients

Comment: Many commenters expressed concern about our clarification in the proposed rule on the applicability of EMTALA to hospital inpatients. Some commenters agreed with the entirety of the CMS proposed policy that a hospital's EMTALA stabilization and transfer obligations should continue to apply to an admitted emergency patient. One commenter stated that "this clarification will

allow hospitals to find an endpoint to their EMTALA obligations, specifically when the patient's emergency [medical] condition is stabilized."

However, many commenters expressed the view that EMTALA should not apply to any inpatient, even one who was admitted through the dedicated emergency department and for whom the hospital had incurred an EMTALA obligation to stabilize. Several commenters noted that hospitals have extensive CoPs responsibilities with respect to inpatients or State tort law obligations, and argued that the hospital's assumption of responsibility for the individual's care on an inpatient basis should be deemed to meet the hospital's obligation under EMTALA. Many commenters recommended that the regulations be revised to state that a hospital's EMTALA obligation may be met by admitting an individual as an inpatient.

Two commenters stated that CMS has "no evidence there is a current problem" for the dumping of inpatients with emergency medical conditions. Therefore, the commenters believed EMTALA applicability should end upon inpatient admission.

One commenter (a group of neurosurgeons and neurologists) believed that EMTALA was not intended to apply to an inpatient admitted through the dedicated emergency department. Several commenters cited the recent ruling by the Court of Appeals for the Ninth Circuit in Bryant v. Adventist Health System (289 F.3d 1162 (9th Cir. 2002)) that EMTALA generally ceases to apply once an individual is admitted for inpatient care; these commenters believed we should adopt the opinion for

the national policy.

Response: In attempting to resolve the issue about EMTALA applicability to admitted emergency patients, we were assisted by referring to cases in which the courts have had to address the same issue. In several instances, the courts concluded that a hospital's obligations under EMTALA end at the time that a hospital admits an individual to the facility as an inpatient. See Bryan v. Rectors and Visitors of the University of Virginia, 95 F.3d 349 (4th Cir. 1996); Bryant v. Adventist Health Systems/West, 289 F.3d 1162 (9th Cir. 2002); and Harry v. Marchant, 291 F.3d 767 (11th Cir. 2002). In reaching this result, the courts focused on the definition of "to stabilize" set out in the statute at section 1867(e)(3)(A) of the Act. In this definition, the Congress defined this concept by specifically linking the hospital's obligation to provide stabilizing treatment to individuals presenting with emergency medical conditions to the context in which the services are provided.

In particular, the courts found that the statute requires that stabilizing care must be provided in a way that avoids material deterioration of an individual's medical condition if the individual is being transferred from the facility. The courts gave great weight to the fact that hospitals have a discrete obligation to stabilize the condition of an individual when moving that individual out of the hospital to either another facility or to his or her home as part of the discharge process. Thus, should a hospital determine that it would be better to admit the individual as an inpatient, such a decision would not

result in either a transfer or a discharge, and, consequently, the hospital would not have an obligation to stabilize under EMTALA. The courts have generally acknowledged that this limitation on the scope of the stabilization requirement does not protect hospitals from challenges to the decisions they make about patient care; only that redress may lie outside EMTALA. For example, a hospital may face liability for negligent behavior that results in harm to persons it treat after they are admitted as inpatients, but such potential liability would flow from medical malpractice principles, not from the hospital's obligations under EMTALA.

As many courts have ruled, EMTALA does not purport to establish a medical malpractice cause of action nor establish a national standard of care. In our view, apart from the possible malpractice implications redressable outside the statute, hospitals that fail to meet their obligations to provide quality care to inpatients may also face consequences affecting their Medicare certification under the applicable CoPs at 42 CFR Part 482. We discuss these CoPs and the process by which we enforce compliance with these CoPs in greater detail in section XIII. of this preamble. In a January 24, 2003 final rule (68 FR 3435), we explained that if our surveyors discover noncompliance with the hospital CoPs, "the hospital will be scheduled for termination from the Medicare and Medicaid programs." Thus, for hospital CoPs violations, as well as for EMTALA violations (compliance with which is a Medicare participation requirement), hospitals face the extreme sanction of termination from the Medicare

program.

As a result of these court cases, and because we believe that existing hospital CoPs provide adequate, and in some cases, superior protection to patients, we are interpreting hospital *53245 obligations under EMTALA as ending once the individuals are admitted to the hospital inpatient care. As an example of a case in which the hospital CoPs provide protection superior to that mandated by EMTALA, the discharge planning CoP in 42 CFR 482.43 includes specific procedural requirements that must be satisfied to show that there has been adequate consideration given to a patient's needs for post-discharge care. EMTALA does not include such specific requirements.

We believe that, as the agency charged with enforcement of EMTALA, it is appropriate to pay deference to the numerous Federal courts of appeal that have decided upon this issue. Although the decisions of the courts in these EMTALA private right of action cases are not necessarily binding for our enforcement purposes, we do believe that consistent judicial interpretation of this matter, when combined with the many comments received on this matter, dictate the policy that we articulate in this final rule.

Moreover, given the numerous hospital CoPs that protect inpatients, as well as patients' rights under State law, we believe that patients are sufficiently protected under our policy as we have articulated it in this final rule. However, a hospital cannot escape liability under EMTALA by ostensibly "admitting" a patient, with no intention of treating the patient, and

then inappropriately transferring or discharging the patient without having met the stabilization requirement. If it is discovered upon investigation of a specific situation that a hospital did not admit an individual in good faith with the intention of providing treatment (that is, the hospital used the inpatient admission as a means to avoid EMTALA requirements), then liability under EMTALA may attach.

2. Definition of Stability

Comment: One commenter took issue with our proposed regulatory language on when EMTALA ends for hospital inpatients at §§ 489.24(d)(2)(ii), which states:
"If a hospital admits an individual with an unstable emergency medical condition for stabilizing treatment, as an inpatient, stabilizes that individual's emergency medical condition, and this period of stability is documented by relevant clinical data in the individual's medical record, the hospital has satisfied its special responsibilities under this section with respect to that individual. If the patient is stable for a transfer of the type usually undertaken with respect to patients having the same medical conditions, the hospital's special responsibilities under this section are satisfied * * *."
The commenter believed the proposed standard, "stable for a transfer of the type usually undertaken with respect to patients having the same medical conditions," could undermine both patient safety and the EMTALA statute if hospitals only document that

a patient is as stable as similarly situated patients for an appropriate transfer. The commenter requested that the final rule specify that the hospital may satisfy its EMTALA obligations to an admitted patient only by documenting that it has provided stabilizing treatment to the point that the emergency medical condition has been resolved.

Response: As stated earlier in this section of the preamble, in this final rule we have decided not to interpret EMTALA as requiring hospitals to continue to provide stabilizing treatment (as that term is understood under EMTALA) to individuals once the individuals are admitted in good faith to the hospital for inpatient care. Therefore, the above comment on documenting stability for inpatients is no longer an issue that we need to address in the inpatient setting. However, as we have also stated above, a hospital that admits patients but do not so do in good faith may face consequences under both EMTALA and the applicable Medicare CoPs.

Comment: Many commenters asked for clarification of when, how, and if EMTALA applies to transfers from the inpatient care setting (when the individual has not yet been stabilized) to another acute care hospital. In addition, many commenters asked for clarification of the issue of "stability" in the inpatient setting. On the one hand, the commenters stated, we have stated that if the admitted emergency patient could have been transferred as "stable" under the statute, the hospital has satisfied its EMTALA obligation by meeting the statutory requirement of providing stabilizing treatment to the point of stability for transfer, and the hospital's obligation

under EMTALA ends (67 FR 31476). However, some commenters pointed out that the statute appears to support a "stable for discharge" standard to end the EMTALA obligation.

Another commenter recommended that we clarify that a hospital inpatient may be stable for transfer or stable for discharge for purposes of EMTALA.

One commenter stated that because of possible confusion on the part of the emergency department staff of what constitutes "stable" under the EMTALA regulations in the inpatient setting, many patients may be identified as stable who are technically medically unstable. The commenter recommended that CMS clarify who the reasonable parties are, to determine whether a patient is stable and can be transported to provide the best outcome for that patient.

Another commenter requested that CMS clarify that once an inpatient has been stabilized for discharge, EMTALA no longer applies, even if the patient requires followup care. The commenter requested guidance on whether, for example, the fact that a patient who is being discharged will eventually need to receive a cast or risk further injury influences the point of stabilization for EMTALA purposes.

One commenter recommended that CMS clarify the EMTALA followup care requirements, for "stable for discharge," until the individual's emergency medical condition is resolved. The commenter suggested that the hospital merely be required to present the individual with a plan for followup care, listing, for example, names of physicians who are qualified to provide the individual's care or who are on the

individual's health care plan.
Response: As noted earlier, we are clarifying in this final rule that EMTALA does not apply to individuals who have been admitted in good faith to inpatient sections of the hospital, regardless of whether the individuals are experiencing emergency medical conditions. Therefore, transfer and stability issues for that individual, once he or she is admitted, would be governed by the Medicare hospital CoPs, State law, and professional considerations, not EMTALA requirements. Regarding the situation of an outpatient who is being released from the hospital but is expected to need followup care at a later time, we note that the EMTALA definition of "to stabilize" requires only that such medical treatment of the condition be provided as may be necessary to assure, within reasonable medical probability, that no material deterioration of the individual's condition is likely to result from the transfer (including discharge) of the individual from the facility. Thus, a hospital clearly may stabilize an individual, thereby satisfying its EMTALA obligation to that individual, even though followup care may be needed.
Comment: One commenter asked us to clarify the preamble language at 67 FR 31475 that discusses the provision that a hospital inpatient admitted with an unstabilized emergency medical condition who goes in and out of apparent stability with sufficient rapidity or frequency would not be *53246 considered "stabilized" within the meaning of §§ 489.24. The commenter requested clarification of the term "medically stable'; that is, whether "stable" in this context refers to the medical definition of "stable."

Response: Again, because we are clarifying in this final rule that, except in limited circumstances, EMTALA does not apply to hospital inpatients, the comment above on stability as an inpatient is not relevant for purposes of EMTALA.

Comment: Several commenters asked us to clarify that EMTALA would not apply to inpatients who are stable but who are scheduled for inpatient surgery for an emergency medical condition, such as patients who need an angiogram or bypass surgery, after seeing their physician for chest pain. One commenter requested clarification on the issue of individuals directly admitted to the hospital for an emergency medical condition, for example, appendicitis, although the individual is not seeking emergency services from the hospital.

Response: As we have clarified above, once an individual has been admitted as an inpatient (including individuals who have been directly admitted as inpatients upon presentation to the hospital), EMTALA no longer applies, except in the limited circumstances discussed above concerning admissions not made in good faith.

3. Logs on EMTALA Patients

Comment: One commenter who supported our proposed policy on the applicability of EMTALA to admitted emergency patients asked whether the hospital inpatient departments would be required to post signs specifying the EMTALA rights of patients and keep a log of patients who are still covered by EMTALA. The commenter also asked whether the

inpatient departments would be required to have EMTALA policy and procedure manuals.
Response: Because we have decided in this final rule that EMTALA does not apply to individuals who are admitted as inpatients in good faith, the comment above concerning the posting of signs, maintenance of logs on inpatients covered by EMTALA, and policies and procedures for EMTALA purposes as described by the commenter will not be required.

4. Other Issues

Comment: One commenter believed that the CMS proposed approach of EMTALA nonapplicability to admitted elective inpatients is inappropriate. The commenter gave several reasons for this belief: Every court in the United States that has considered the issue of hospital obligation has concluded that EMTALA application commenced when the hospital or its agents "became aware" that the individual had an emergency medical condition or was unstable as provided by the law; the U.S. Supreme Court case in Roberts v. Galen of Virginia, 525 U.S. 249 (1999) specifically stated that the obligations to stabilize, provide additional care or provide an appropriate transfer, or both, are completely unrelated to whether or not the patient came to the emergency department under section 1867(a) of the Act; and Lopez-Soto v. Hawayek, 175 F.3d 170 (1st Cir. 1999), interpreted the Roberts case and addressed and rejected the arguments made by CMS in support of the CMS interpretation of the law and held that once the patient was in the hospital, EMTALA attached

when the hospital or doctor knew of the unstable condition.

Response: We disagree with the commenter. After reviewing the EMTALA statute and its legislative history, we find no indication that Congress intended EMTALA to apply to hospital inpatients. To the contrary, the legislative history makes several references to individuals who were denied emergency medical care at hospital emergency rooms, but we find no references to similar problems faced by hospital inpatients. (See H.R. Rept. No. 99-241 (I), at 27 (1985), reprinted in 1986 U.S.C.C.A.N. 579, 605.) Therefore, we believe that Congress intended for EMTALA to address the issue of inadequate emergency care for individuals who presented with emergency medical conditions seeking such care from hospital emergency departments. Moreover, while we are not bound by judicial precedent in cases in which we were not a party, we are familiar with the Roberts v. Galen, 525 U.S. 249 (199), and Lopez-Soto v. Hawayek, 175 F.3d 170 (1st Cir. 1999) cases and believe that they do not pose any barrier to the position we are taking in this rule.

In Roberts, the Court addressed the issue of whether an individual must prove that a hospital acted with an improper motive in failing to stabilize that individual and concluded that the stabilization provision found in the Social Security Act at section 1867(b)(1) contained no such requirement. The Court did not address the issue of when a hospital's EMTALA obligation to stabilize an individual ends. However, the Lopez-Soto case did address the stabilization issue, and in that case the court

concluded that a hospital has an obligation to stabilize an individual with an emergency medical condition before arranging a transfer of that person to another facility, regardless of whether the individual presented to the emergency department with the emergency medical condition or elsewhere at the hospital.

Because the court in Lopez-Soto was not clear about the inpatient status of the individual, a baby, it is not clear to us whether this decision is necessarily inconsistent with the view of the statute we are taking in this final rule. For example, if the baby in Lopez-Soto was not an inpatient at the time it presented with an emergency medical condition, then we would agree that the hospital, under this final rule, would be obligated to respond to the baby's condition as if it had been initially presented to the hospital's emergency department. On the other hand, if the baby were, in fact, an inpatient at the time the emergency first presented itself to hospital staff, the court's holding would be inconsistent with the views adopted in this final rule, and, to this extent, we would disagree with the court's conclusion. As we have explained elsewhere in this preamble, we believe such a conclusion oversteps the requirement of the statute that limits its scope to individuals who have presented themselves to a hospital prior to the time they become an inpatient of that facility.

However, this is not to say that hospitals are without patient obligations in these cases. Hospitals clearly owe a duty to inpatients, but those obligations derive from the Medicare hospital CoPs at section 1861(e) of the Act and the implementing regulations at 42 CFR

Part 482, not from EMTALA. In addition, as we have stated, if it is discovered upon investigation of a specific situation that a hospital did not admit an individual in good faith with the intention of providing treatment, but instead used the inpatient admission merely as a means to avoid EMTALA requirements, then liability under EMTALA may attach.

Comment: One commenter who did not support our proposed policy on the nonapplicability of EMTALA to admitted elective patients requested that we clarify the EMTALA obligations to such individuals who experience an emergency after being admitted to the hospital. Specifically, the commenter was concerned about the transfer of such an unstable individual to a hospital that has special capabilities to treat the individual.

Response: Since EMTALA is not triggered for admitted elective patients who experience an emergency during the inpatient admission, (except in limited circumstances), the EMTALA transfer requirements would not apply *53247 to the transfer of such an individual to another hospital.

Comment: One commenter stated that our language in the preamble that discusses the applicability of EMTALA to "admitted emergency patients" (67 FR 31476) appears to apply only to patients admitted via the emergency department, whereas the language in the proposed regulatory text at §§ 489.24(d)(2)(ii) states that EMTALA applies to inpatient care "if a hospital admits an individual with unstable emergency medical condition for stabilizing treatment." The commenter requested us to clarify

whether EMTALA applies in the inpatient setting but only to an individual admitted via the dedicated emergency department or whether it applies to any individual who has an emergency medical condition.
Response: As stated earlier, our decision in this final rule is that EMTALA no longer applies to any individual who is admitted as an inpatient (except in limited circumstances of circumvention.)
Comment: One commenter recommended that the definition of "inpatient" for purposes of EMTALA would specifically include patients who have been admitted to the hospital but, due to bed availability, are being "boarded" and physically located in the dedicated emergency department.
Another commenter asked us to clarify whether EMTALA would apply to the stabilization of individuals with emergency medical conditions while awaiting admission in the dedicated emergency department or to an unstable patient who is being "held" or "boarded" in the operating room or angiography suite prior to movement to an inpatient bed.
Response: As we have stated, EMTALA applies to an individual who presents to the hospital with an emergency medical condition. If such a condition is found when the individual is screened, the hospital must provide stabilizing treatment, even if the individual is awaiting admission in the dedicated emergency department. Once the individual has been stabilized, the EMTALA obligations end.
In response to the issue about the definition of "inpatient" for purposes of EMTALA, we are revising our proposed definition of "patient" under §§

489.24(b) that specified that an inpatient is one who is "receiving inpatient hospital services as defined in §§ 409.10(b)." Upon further consideration, we believe it would be more helpful to adopt the definition of "inpatient" from Section 210 of the Medicare Hospital Manual (CMS Publication Number 10 (1989)), which is a well-utilized definition in the Medicare program for purposes of Medicare payment. Under that section, an "inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he [or she] will remain at least overnight and occupy a bed even though it later develops that he [or she] can be discharged or transferred to another hospital and does not actually use a hospital bed overnight." We believe adopting such a definition for EMTALA purposes would provide further guidance in determining who is an inpatient.

To respond specifically to the commenter, individuals who are "boarded" and admitted in the dedicated emergency department would be determined to be inpatients for purposes of EMTALA if, generally, they have been admitted by the hospital with the expectation that they will remain at least overnight and occupy beds in the hospital. We believe such an expectation would be documented based on the information in the individual's medical record.

Comment: One commenter compared the proposed regulatory language regarding the application of EMTALA to inpatients in proposed §§ 489.24(d)(2)(i)

to the language in proposed §§ 489.24(d)(2)(ii). The commenter stated that although paragraph (d)(2)(i) requires the hospital to have found the emergency medical condition and have actual knowledge that the condition exists, before it can incur a duty to stabilize under EMTALA, paragraph (d)(2)(ii) does not require that the hospital be aware that the individual had an emergency medical condition at the time of admission.

Response: Proposed §§ 489.24(d)(2) was based on the proposed policy that EMTALA applied to an individual who was admitted as an inpatient. In this final rule, we are revising our policy to state that EMTALA obligations end toward an individual upon inpatient admission, regardless of the stability of the individual (except in limited circumstances of circumvention). Because we are revising the regulation text to reflect this revised policy, the above comment on proposed §§ 489.24(d)(2) is no longer relevant.

Comment: One commenter suggested that the final rule should clarify the application of the psychiatric specific definitions of "stable for transfer" and "stable for discharge" in the State Operations Manual.

Response: In the 1998 State Operations Manual at Tag A407 on page V-9, we state: "for purposes of transferring a patient from one facility to a second facility for psychiatric conditions, the patient is considered to be stable when he/she is protected and prevented from injuring himself/herself or others. For purposes of discharging a patient (other than for the purpose of transfer from one facility to a second facility), for psychiatric conditions, the patient is

considered to be stable when he/she is no longer considered to be a threat to him/herself or to others." However, we note that, generally, psychiatric patients with emergency medical conditions are treated no differently for purposes of EMTALA than any other individual who presents to the hospital with an emergency medical condition. We intend to address the issue of treatment of individuals with psychiatric conditions for purposes of EMTALA in future operating instructions for our State surveyors.

Comment: The commenter also suggested that the final rule clarify that any retrospective review of a physician's determination that an individual is stable will only be based upon the information and clinical data readily available at the time of such determination.

Response: We will keep in mind the commenter's suggestion about retrospective review when we develop future operating instructions for our State surveyors. In addition, the commenter has stated our current position as specified in the 1998 State Operations Manual, page V-9: "the purpose of the professional medical review (physician review) is to provide peer review using information available to the hospital at the time the alleged violation took place."

Comment: One commenter asked for clarification on the point of whether EMTALA should apply when an ambulance delivers an individual through the dedicated emergency department as a direct admit.

Response: As we have clarified above, whenever there is a direct admission of a particular individual as an inpatient, EMTALA no longer applies.

C. Provisions of the Final Rule

In this final rule, we are adopting as final the proposed definition of "patient" under §§ 489.24(b) with modifications. We are further clarifying what "outpatients" are not subject to the EMTALA obligations.

We also are providing that a hospital's obligations under EMTALA end once an individual is admitted for inpatient care. As explained above, we believe *53248 that this is the appropriate policy because existing hospital CoPs provide adequate, and in some cases, superior protection to inpatients. (See section XIII. of this preamble for a detailed discussion of regarding the hospital CoPs). In addition, numerous courts have held that EMTALA obligations end upon inpatient admission. At least two courts ruled on the identical issue after we published our May 9, 2002 proposed rule.

We also are adding language to adopt our established definition of "inpatient" in section 210 of the Medicare Hospital Manual (CMS Publication No. 10) who are also not subject to the EMTALA obligations.

In addition, we are adopting as final the proposed §§ 489.24(d)(2) with modifications. We are clarifying that a hospital is required to provide care to its inpatients in accordance with the Medicare hospital CoPs.

. . .

Appendix I - 42 C.F.R. §§ 489.24

SPECIAL RESPONSIBILITIES OF MEDICARE HOSPITALS IN EMERGENCY CASES.

(a) Applicability of provisions of this section.

(1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must--

(i) Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §§ 482.55 of this chapter concerning emergency services personnel and direction; and

(ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer

as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.

(2) Nonapplicability of provisions of this section. Sanctions under this section for an inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72 hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.

(b) Definitions. As used in this subpart--

Capacity means the ability of the hospital to accommodate the individual requesting examination or treatment of the transferred individual. Capacity encompasses such things as numbers and

availability of qualified staff, beds and equipment and the hospital's past practices of accommodating additional patients in excess of its occupancy limits.

Comes to the emergency department means, with respect to an individual who is not a patient (as defined in this section), the individual--

(1) Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;

(2) Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;

(3) Is in a ground or air ambulance owned and

operated by the hospital for purposes of examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. However, an individual in an ambulance owned and operated by the hospital is not considered to have "come to the hospital's emergency department" if--

(i) The ambulance is operated under communitywide emergency medical service (EMS) protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the closest appropriate facility. In this case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property;

(ii) The ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance; or

(4) Is in a ground or air nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. However, an individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and

treatment. The hospital may direct the ambulance to another facility if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's diversion instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.

Dedicated emergency department means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

(1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;

(2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

(3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

Emergency medical condition means--

(1) A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in--

(i) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part; or

(2) With respect to a pregnant woman who is having contractions--

(i) That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

Hospital includes a critical access hospital as defined in section 1861(mm)(1) of the Act.

Hospital property means the entire main hospital campus as defined in §§ 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway,

but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.

Hospital with an emergency department means a hospital with a dedicated emergency department as defined in this paragraph (b).

Inpatient means an individual who is admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services as described in §§ 409.10(a) of this chapter with the expectation that he or she will remain at least overnight and occupy a bed even though the situation later develops that the individual can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

Labor means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife, or other qualified medical person acting within his or her scope of practice as defined in hospital medical staff bylaws and State law, certifies that, after a reasonable time of observation, the woman is in false labor.

Participating hospital means (1) a hospital or (2) a critical access hospital as defined in section

1861(mm)(1) of the Act that has entered into a Medicare provider agreement under section 1866 of the Act.

Patient means--

(1) An individual who has begun to receive outpatient services as part of an encounter, as defined in §§ 410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;

(2) An individual who has been admitted as an inpatient, as defined in this section.

Stabilized means, with respect to an "emergency medical condition" as defined in this section under paragraph (1) of that definition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, that the woman has delivered the child and the placenta.

To stabilize means, with respect to an "emergency medical condition" as defined in this section under paragraph (1) of that definition, to provide such medical treatment of the condition necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the

individual from a facility or that, with respect to an "emergency medical condition" as defined in this section under paragraph (2) of that definition, the woman has delivered the child and the placenta.

Transfer means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

(c) Use of dedicated emergency department for nonemergency services. If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

(d) Necessary stabilizing treatment for emergency medical conditions.--

(1) General. Subject to the provisions of paragraph (d)(2) of this section, if any individual (whether or not eligible for

Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either--

(i) Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition.

(ii) For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.

(2) Exception: Application to inpatients.

(i) If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.

(ii) This section is not applicable to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.

(iii) A hospital is required by the conditions of

participation for hospitals under Part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

(3) Refusal to consent to treatment. A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) does not consent to the examination or treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

(4) Delay in examination or treatment.

(i) A participating hospital may not delay

providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.

(ii) A participating hospital may not seek, or direct an individual to seek, authorization from the individual's insurance company for screening or stabilization services to be furnished by a hospital, physician, or nonphysician practitioner to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.

(iii) An emergency physician or nonphysician practitioner is not precluded from contacting the individual's physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraphs (d)(1) and (d)(2) of this section.

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by this section, including asking whether an individual is insured and, if so, what that insurance is, as long as that inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.

(5) Refusal to consent to transfer. A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) does not consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer

that was refused by or on behalf of the individual.

(e) Restricting transfer until the individual is stabilized--

(1) General. If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless--

(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and

(ii)(A) The individual (or a legally responsible person acting on the individual's behalf) requests the transfer, after being informed of the hospital's obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer;

(B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision

of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the risks and benefits upon which it is based; or

(C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.

(2) A transfer to another medical facility will be appropriate only in those cases in which--

(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual's health and, in the

case of a woman in labor, the health of the unborn child;

(ii) The receiving facility--

(A) Has available space and qualified personnel for the treatment of the individual; and

(B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment;

(iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer, including available history, records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, results of diagnostic studies or telephone reports of the studies, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) required under paragraph (e)(1)(ii) of this section, and the name and address of any on-call physician (described in paragraph (g) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment. Other

records (e.g., test results not yet available or historical records not readily available from the hospital's files) must be sent as soon as practicable after transfer; and

(iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.

(3) A participating hospital may not penalize or take adverse action against a physician or a qualified medical person described in paragraph (e)(1)(ii)(C) of this section because the physician or qualified medical person refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized, or against any hospital employee because the employee reports a violation of a requirement of this section.

(f) Recipient hospital responsibilities. A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers, which, for purposes of this subpart, means hospitals meeting the requirements of referral centers found at §§ 412.96 of this chapter) may not refuse to accept from a referring hospital within the

boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.

(g) Termination of provider agreement. If a hospital fails to meet the requirements of paragraph (a) through (f) of this section, CMS may terminate the provider agreement in accordance with §§ 489.53.

(h) Consultation with Quality Improvement Organizations (QIOs)--

(1) General. Except as provided in paragraph (h)(3) of this section, in cases where a medical opinion is necessary to determine a physician's or hospital's liability under section 1867(d)(1) of the Act, CMS requests the appropriate QIO (with a contract under Part B of title XI of the Act) to review the alleged section 1867(d) violation and provide a report on its findings in accordance with paragraph (h)(2)(iv) and (v) of this section. CMS provides to the QIO all information relevant to the case and within its possession or control. CMS, in consultation with the OIG, also provides to the QIO a list of relevant questions to which the QIO must respond in its report.

(2) Notice of review and opportunity for discussion and additional information. The QIO shall provide the physician and hospital reasonable notice of its review, a reasonable opportunity for discussion, and an opportunity for the physician and hospital to submit additional information before issuing its report. When a QIO receives a request for consultation under paragraph (h)(1) of this section, the following provisions apply--

(i) The QIO reviews the case before the 15th calendar day and makes its tentative findings.

(ii) Within 15 calendar days of receiving the case, the QIO gives written notice, sent by certified mail, return receipt requested, to the physician or the hospital (or both if applicable).

(iii)

(A) The written notice must contain the following information:

(1) The name of each individual who may have been the subject of the alleged violation.

(2) The date on which each alleged violation occurred.

(3) An invitation to meet, either by telephone or in person, to discuss the case with the QIO, and to submit additional information to the QIO within 30 calendar days of receipt of the notice, and a statement that these rights will be waived if the invitation is not accepted. The QIO must receive the information and hold the meeting within the 30-day period.

(4) A copy of the regulations at 42 CFR 489.24.

(B) For purposes of paragraph (h)(2)(iii)(A) of this section, the date of receipt is presumed to be 5 days after the certified mail date on the notice, unless there is a reasonable showing to the contrary.

(iv) The physician or hospital (or both where applicable) may request a meeting with the QIO. This meeting is not designed to be a formal adversarial hearing or a mechanism for discovery by the physician or hospital. The meeting is intended to afford the physician and/or the hospital a full and fair opportunity to present the views of the physician and/or

hospital regarding the case. The following provisions apply to that meeting:

> (A) The physician and/or hospital has the right to have legal counsel present during that meeting. However, the QIO may control the scope, extent, and manner of any questioning or any other presentation by the attorney. The QIO may also have legal counsel present.
>
> (B) The QIO makes arrangements so that, if requested by CMS or the OIG, a verbatim transcript of the meeting may be generated. If CMS or OIG requests a transcript, the affected physician and/or the affected hospital may request that CMS provide a copy of the transcript.
>
> (C) The QIO affords the physician and/or the hospital an opportunity to present, with the assistance of counsel, expert testimony in either oral or written form on the medical issues presented. However, the QIO may reasonably limit the number of witnesses and length of such testimony if such testimony is irrelevant or repetitive. The physician and/or hospital, directly or through counsel, may disclose patient records to potential expert witnesses without violating any

non-disclosure requirements set forth in part 476 of this chapter.

(D) The QIO is not obligated to consider any additional information provided by the physician and/or the hospital after the meeting, unless, before the end of the meeting, the QIO requests that the physician and/or hospital submit additional information to support the claims. The QIO then allows the physician and/or the hospital an additional period of time, not to exceed 5 calendar days from the meeting, to submit the relevant information to the QIO.

(v) Within 60 calendar days of receiving the case, the QIO must submit to CMS a report on the QIO's findings. CMS provides copies to the OIG and to the affected physician and/or the affected hospital. The report must contain the name of the physician and/or the hospital, the name of the individual, and the dates and times the individual arrived at and was transferred (or discharged) from the hospital. The report provides expert medical opinion regarding whether the individual involved had an emergency medical condition, whether the individual's emergency medical condition was stabilized, whether the individual was transferred appropriately, and whether there

were any medical utilization or quality of care issues involved in the case.

(vi) The report required under paragraph (h)(2)(v) of this section should not state an opinion or conclusion as to whether section 1867 of the Act or §§ 489.24 has been violated.

(3) If a delay would jeopardize the health or safety of individuals or when there was no screening examination, the QIO review described in this section is not required before the OIG may impose civil monetary penalties or an exclusion in accordance with section 1867(d)(1) of the Act and 42 CFR part 1003 of this title.

(4) If the QIO determines after a preliminary review that there was an appropriate medical screening examination and the individual did not have an emergency medical condition, as defined by paragraph (b) of this section, then the QIO may, at its discretion, return the case to CMS and not meet the requirements of paragraph (h) except for those in paragraph (h)(2)(v).

(i) Release of QIO assessments. Upon request, CMS may release a QIO assessment to the physician and/or hospital, or the affected individual, or his or her representative. The QIO physician's identity is

confidential unless he or she consents to its release. (See §§§§ 476.132 and 476.133 of this chapter.)

(j) Availability of on-call physicians.

(1) Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients who are receiving services required under this section in accordance with the resources available to the hospital, including the availability of on-call physicians.

(2) The hospital must have written policies and procedures in place--

(i) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control; and

(ii) To provide that emergency services are available to meet the needs of patients with emergency medical conditions if it elects to permit on-call physicians to schedule elective surgery during the time that they are on call or to permit on-call physicians to have simultaneous on-call duties.

[62 FR 46037, Aug. 29, 1997; 65 FR 18548, April 7, 2000; 65 FR 40535, June 30, 2000; 65 FR 58919, Oct. 3, 2000; 65 FR 59748, Oct. 6, 2000; 66 FR 1599, Jan. 9, 2001; 66 FR 59923, Nov. 30, 2001; 68 FR 53262, Sept. 9, 2003; 71 FR 48143, Aug. 18, 2006; 72 FR 47413, Aug. 22, 2007]